CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

JULY 1991

Selected Options for Expanding Health Insurance Coverage

A CBO STUDY

J932-21

SELECTED OPTIONS FOR EXPANDING HEALTH INSURANCE COVERAGE

The Congress of the United States
Congressional Budget Office

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

NOTES

Unless otherwise indicated, all years referred to in the text are calendar years.

Details in the text and tables of this report may not add to totals because of rounding.

PREFACE

In response to separate requests from the Subcommittee on Health and the Environment of the Committee on Energy and Commerce and from the Subcommittee on Health of the Committee on Ways and Means, this study analyzes two major approaches for substantially reducing the number of uninsured people. One would expand employment-based coverage, while the other would cover more people under Medicaid.

This report was written by Jack Rodgers of CBO's Human Resources and Community Development Division (HRCD) under the direction of Nancy M. Gordon and Kathryn M. Langwell. Bryan Sayer did the computer programming. Stephen H. Long, formerly of HRCD, made many substantial contributions to this study, particularly in developing the estimation methods that Appendix A describes.

Many others contributed to this report. Alan Fairbank and Jean P. Hearne of CBO's Budget Analysis Division provided many of the federal budget cost estimates. Maureen Griffin and Roberton Williams of CBO's Tax Analysis Division were responsible for the federal, state, and local tax estimates. Ross H. Arnett III and Katharine R. Levit of the Office of the Actuary of the Health Care Financing Administration provided invaluable assistance in the estimation of the impact of various options on national health expenditures. Gordon R. Trapnell and James W. Mays of the Actuarial Research Corporation were the source of insurance premium estimates.

Drafts of this study benefited from external reviews by Louis F. Rossiter of the Health Care Financing Administration, Barbara S. Selfridge of the Office of Management and Budget, and Stuart M. Butler of the Heritage Foundation. Internal reviewers, including Philip Joyce, Wilhelmina A. Leigh, and Murray Ross, also commented on drafts.

Paul L. Houts edited the manuscript. Nancy H. Brooks provided editorial assistance during production of the report. Sharon Corbin-Jallow typed portions of various drafts, and Martina Wojak prepared the report for publication.

Robert D. Reischauer
Director

July 1991

CONTENTS

	SUMMARY	xi
I	INTRODUCTION	1
	Major Sources of Health Insurance *2* Trends in Insurance Coverage *6* The Uninsured *8*	
II	ANALYSIS OF OPTIONS THAT WOULD EXPAND EMPLOYMENT-BASED HEALTH INSURANCE	17
	An Illustrative Mandated Health Insurance Option *18* An Analysis of the Illustrative Option *20* Alternative Specifications *32* Advantages and Disadvantages of Employer Mandates *38*	
III	ANALYSIS OF OPTIONS THAT WOULD EXPAND MEDICAID	41
	An Illustrative Medicaid Expansion *42* An Analysis of the Illustrative Plan *43* Alternative Specifications *48* Advantages and Disadvantages of Expanding Medicaid *51*	
IV	ANALYSIS OF OPTIONS THAT EXPAND BOTH EMPLOYMENT-BASED HEALTH INSURANCE AND MEDICAID	55
	An Illustrative Combination Plan *55* Analyzing the Illustrative Plan *56* Alternative Specifications *63* Advantages and Disadvantages of the Combined Approach *66*	

APPENDIX

A ESTIMATING PROCEDURES 69

TABLES

S-1.	Characteristics of the Uninsured, 1990	xii
S-2.	Insurance Status of People Before and After Enactment of Illustrative Options	xvi
S-3.	Characteristics of the Uninsured Before and After Enactment of Illustrative Options	xviii
S-4.	National Health Expenditures Before and After Enactment of Illustrative Options	xix
1.	Source of Insurance Coverage for the United States Population, by Age, 1990	4
2.	Trends in Health Insurance Coverage, 1978-1989	7
3.	Characteristics of the Uninsured, 1990	10
4.	Employers' Offers of Health Insurance and Employees' Responses, 1988	13
5.	Workers and Dependents Affected by an Illustrative Employer Mandate	20
6.	Characteristics of the Uninsured Before and After Enactment of an Illustrative Employer Mandate	22
7.	National Health Expenditures Before and After Enactment of an Illustrative Employer Mandate	25
8.	Characteristics of Workers Affected by an Illustrative Employer Mandate	28

9.	Effects on the Federal Budget of an Illustrative Employer Mandate	31
10.	Effects of an Illustrative Employer Mandate Under Different Threshold Hours of Work	33
11.	Effects of an Illustrative Employer Mandate Under Alternative Exemptions for Small Firms	35
12.	Direct Costs of an Illustrative Employer Mandate Under Alternative Levels of Benefits	37
13.	Insurance Status of People Before and After Enactment of an Illustrative Medicaid Expansion	44
14.	Characteristics of the Uninsured Before and After Enactment of an Illustrative Medicaid Expansion	46
15.	National Health Expenditures Before and After Enactment of an Illustrative Medicaid Expansion	48
16.	Effects of an Illustrative Medicaid Expansion Under Alternative Poverty Levels	49
17.	Insurance Status of People Before and After Enactment of Both an Illustrative Employer Mandate and an Illustrative Medicaid Expansion	57

18. Characteristics of the Uninsured Before and After Enactment of Both an Illustrative Employer Mandate and an Illustrative Medicaid Expansion 58

19. National Health Expenditures Before and After Enactment of Both an Illustrative Employer Mandate and an Illustrative Medicaid Expansion 61

20. Effects on the Federal Budget of Both an Illustrative Employer Mandate and an Illustrative Medicaid Expansion 62

A-1. Characteristics of Typical Insurance Plans Covering Employees at Selected Levels of Employer Generosity 74

BOXES

S-1. Description of Three Illustrative Options xiv

1. Alternative Combinations of Employer Mandates and Medicaid Expansions 64

SUMMARY

In March 1990, 33 million people, or about one in seven people in the United States, were uninsured. Because they lack financial access, the uninsured receive less medical care compared with the insured. Two approaches--mandating employment-based coverage and expanding the Medicaid program--could substantially reduce the number of uninsured people, while keeping most existing arrangements for insurance intact because four-fifths of the uninsured live in families where at least one adult is employed and three-fifths have family incomes below 200 percent of their poverty thresholds.

HEALTH INSURANCE AND THE UNINSURED

Most people--about 85 percent of the nonelderly and 99 percent of the elderly--have health insurance. Employment-based insurance is the most common--62 percent have this type of coverage. Public programs--Medicare, Medicaid, and Veterans Affairs (VA)--provide coverage for another 19 percent of the population. More than 6 percent of the population have purchased private insurance policies unrelated to employment.

Almost 14 percent--33.4 million people--do not have health insurance, however. They tend to be people who live in families with an unemployed worker, the poor and near-poor, young adults, nonwhite Americans, and members of single-parent families (see Summary Table 1).

ILLUSTRATIVE OPTIONS

Three possibilities for expanding health insurance coverage are an employer mandate, a Medicaid expansion, and a combination of the two (see Summary Box for details). Under the illustrative mandate, all employers with 10 or more employees would be required to offer, and

SUMMARY TABLE 1. CHARACTERISTICS OF THE UNINSURED, 1990

Characteristic	Number (Millions)	Uninsured As a Percentage of Category	As a Percentage of All Uninsured
All Uninsured	33.4	13.6	100.0
Family Work Status[a]			
Employed	26.8	13.9	80.2
Unemployed	2.0	31.9	6.1
Not in labor force	4.6	9.8	13.7
Family Income as a Percent of Poverty (1989)			
Below 200	20.2	26.1	60.6
200 or higher	13.1	7.8	39.4
Age and Sex			
Children	8.5	13.3	25.6
Young adults, 18 to 24	6.4	25.1	19.0
Women, 25 to 64	8.6	13.2	25.7
Men, 25 to 64	9.6	15.5	28.7
Elderly, 65 and over	0.3	1.0	0.9
Race			
White	25.9	12.5	77.5
Black	5.8	19.2	17.5
Other	1.7	19.1	5.0
Family Structure			
Unrelated individual	6.0	16.9	17.9
Single-parent family	9.1	21.8	27.2
Two-parent family	15.7	12.3	47.1
Childless couple	2.6	6.3	7.8

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

a. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head nor spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

pay at least 75 percent of the cost of, a qualified insurance plan to employees who worked 25 hours or more a week and to the dependents of these employees. The illustrative Medicaid expansion would offer coverage to individuals and families regardless of their age or family circumstances, provided their family incomes were below 200 percent of their poverty thresholds.

Each of the illustrative options would potentially provide health insurance coverage for one-half or more of the currently uninsured. In addition, each option would affect millions of people who currently have insurance by changing the source of their coverage. Finally, each of the options would affect national health spending and its components with implications for the federal budget and the rest of the economy.

Any number of specifications that would carry out these approaches could be devised. These variations would raise or lower the number of uninsured who would be covered and would affect the advantages and disadvantages of each as well. The illustrative employer mandate could be varied, for example, by changing the hours of work per week for a worker to be covered, the exemption for small businesses, the minimum level of benefits, or the share the employee would pay. Similarly, the family income threshold for a Medicaid expansion could be raised or lowered or eligibility could be limited to certain categories of people--for example, families with children. Moreover, the combined approach could be varied by changing either component.

Effects on People

The illustrative employer mandate would change the health insurance coverage of 30.6 million people. In addition to providing coverage for 17.6 million previously uninsured people, it would also replace Medicare, Medicaid, VA, and individually purchased private insurance with employment-based coverage for some workers and their dependents who are covered by these plans (see Summary Table 2).

Summary Box
Description of Three Illustrative Options

The analysis in this study is based on three illustrative options. Each is described in detail below.

MANDATED HEALTH INSURANCE

This illustrative option would require employers to provide insurance to employees and their dependents. More specifically:

- All employers with 10 or more employees, including governments, would have to offer a qualified insurance plan to employees who worked 25 hours or more per week and to dependents of these employees;
- Dependents, other than spouses, would have to be covered through age 18 (age 23 for full-time students);
- Employers would have to pay at least 75 percent of the premiums;
- Eligible employees would be required to accept the coverage and pay up to 25 percent of the premiums;
- Working spouses might be covered by their own or their spouses' plans at the employees' discretion, but would have to be covered by at least one of them;
- Children might be covered by either spouse's plan at the employee's discretion, but would have to be covered by at least one of them;
- Employers would have to provide benefits equivalent to a minimum plan: a single annual deductible of $250 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $875. These provisions, which would cost about $2,900 for a family in 1991, would be more generous than the plans currently provided to the 10 percent of employees with the least adequate coverage; and
- Firms with fewer than 25 employees (but at least 10) would be required to purchase their insurance through an insurance pool. The pool would provide a choice of health insurance plans, the least

adequate of which would meet the requirements of the minimum plan. Premiums would be based on a community rating.

MEDICAID EXPANSION

The illustrative Medicaid option would:

- Expand Medicaid coverage to all individuals and families (without cost to them), regardless of their age or family circumstances, provided their family incomes were below 100 percent of poverty; and

- Allow individuals and families whose incomes are below 200 percent of the poverty level (but greater than or equal to 100 percent of the poverty level) to "buy in" to Medicaid based on a sliding scale of contributions, thereby avoiding any "notches" where a small increase in income would cause a substantial increase in the cost of participating. Specifically, the contribution or "premium" would be the smallest of the following:

  - Five percent of all family income above the poverty threshold for each covered family member; or,

  - Ten percent of all family income above the poverty threshold; or,

  - One-third of total costs of Medicaid coverage for an average family of this size and type.

- Maintain copayments by beneficiaries as under current Medicaid rules.

COMBINATION PLAN

This plan would combine the illustrative employer mandate with the illustrative Medicaid expansion. Workers and their dependents would receive employment-based coverage under the mandate, but would have Medicaid as a second payer if their family income was under 100 percent of poverty. Nonworkers and their families would be eligible for primary coverage from Medicaid if their family incomes were below their poverty thresholds.

SUMMARY TABLE 2. INSURANCE STATUS OF PEOPLE BEFORE AND AFTER ENACTMENT OF ILLUSTRATIVE OPTIONS (In millions)

Source of Insurance	Before Enactment	Changes in Insurance Coverage After Enactment of: Employer Mandate	Medicaid Expansion	Combination
Employment-Based	152.3	30.6	0	30.6
Medicare	30.5	-1.7	0	-1.7
Medicaid	14.6	-2.8	25.3[a]	11.0
Veterans Affairs	0.8	-0.4	-0.3	-0.6
Other private	14.7	-8.2	-4.7	-11.0
None	33.4	-17.6	-20.2	-28.4

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

NOTE: In general, people covered by more than one source of insurance are classified by the primary source. For example, retired elderly Medicare beneficiaries are classified there, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. In contrast, the working aged, whose plans are primary payers to Medicare, are classified under employment-based coverage.

a. This figure does not include 6.8 million people who would get new Medicaid second-payer coverage--4.3 million with employment-based policies as first payer and 2.5 million with Medicare as first payer.

Although the illustrative Medicaid expansion would change the coverage of fewer people, it would provide new coverage for more of the uninsured. Of 25.3 million people newly eligible for Medicaid under the illustrative expansion, 20.2 million would be previously uninsured. Another 5.1 million would previously be covered by VA or individually purchased policies. Not all of these potential beneficiaries would participate, however, especially among those with family incomes above the poverty level who would have to make a contribution in order to receive coverage.

The illustrative combination option would change the coverage of up to 44.4 million people--roughly 18 percent of the U.S. population. About 30.6 million would have new employment-based coverage and 13.8 million would be new Medicaid beneficiaries.[1] In total, up to 28.4

1. Summary Table 2 shows the net change in Medicaid coverage of 11.0 million--13.8 million new Medicaid beneficiaries less 2.8 million current beneficiaries who would receive new employment-based coverage.

million of the previously uninsured would be covered, leaving as few as 5.0 million Americans uninsured.

The three options would differ in how they would affect various demographic groups. The illustrative employer mandate would cover almost two-thirds of the uninsured who live in working families (see Summary Table 3). The employer mandate would affect the uninsured with family incomes at or above 200 percent of poverty more than it would affect those with family incomes below 200 percent of poverty--about 62 percent of the uninsured with family incomes of 200 percent of poverty or higher would receive new coverage compared with about 47 percent of those with family incomes below that level.

The illustrative Medicaid expansion would cover the poor and near-poor--everyone in families below 200 percent of poverty would be eligible for new coverage under Medicaid, although some people would not participate. This option could also potentially provide coverage for more than half of the uninsured who live in working families because they have family incomes below 200 percent of poverty.

The illustrative combination would affect both the uninsured who live in families where the head or spouse works 25 hours or more and those who live in families with incomes below 200 percent of poverty. About 86 percent of the uninsured in working families and all of the poor and near-poor uninsured would be eligible for new coverage.

Effects on Health Spending

None of the three options would increase national health expenditures by more than 3 percent, but all of them would have redistributional consequences that would substantially exceed the modest net effect on overall health spending. The overall increase would be modest, because the uninsured are assumed to receive about half of the medical care the insured obtain. A substantial redistribution of spending would, however, occur under each of the illustrative options because many of the currently insured would switch from one type of coverage to another, with corresponding changes in spending by business, government, and individuals.

292-891 0 - 91 - 2

SUMMARY TABLE 3. CHARACTERISTICS OF THE UNINSURED BEFORE AND AFTER ENACTMENT OF ILLUSTRATIVE OPTIONS

Characteristic	Uninsured Before Enactment (Millions)	Percentage of Uninsured Eligible for Coverage After Enactment of:		
		Employer Mandate	Medicaid Expansion	Combination
All Uninsured	33.4	52.6	60.6	84.9
Family Work Status[a]				
Employed	26.8	65.6	55.6	85.9
Unemployed	2.0	0	78.7	78.7
Not in labor force	4.6	0	82.1	82.1
Family Income as a Percent of Poverty (1989)				
Below 200	20.2	46.7	100.0	100.0
200 or higher	13.1	61.7	0	61.7
Age and Sex				
Children	8.5	59.1	73.6	93.1
Young Adults, 18 to 24	6.4	52.3	55.0	81.4
Women, 25 to 64	8.6	48.9	62.1	85.1
Men, 25 to 64	9.6	51.5	51.6	80.3
Elderly, 65 and over	0.3	17.0	58.3	67.9
Race				
White	25.9	54.1	58.2	83.9
Black	5.8	45.6	72.4	89.5
Other	1.7	54.4	56.4	85.1
Family Structure				
Unrelated individual	6.0	43.4	67.4	86.4
Single-parent family	9.1	43.3	67.4	84.5
Two-parent family	15.7	60.8	56.5	84.7
Childless couple	2.6	56.4	46.3	83.9

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

a. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head nor spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

The illustrative employer mandate would increase premiums for employment-based insurance by $35 billion, or about 16 percent (see Summary Table 4). A $22 billion reduction for other payers would offset this increase in health spending--$5 billion for individually purchased insurance policies, $8 billion in government spending, and $9 billion in direct patient spending. The net increase in national health expenditures would be $13 billion, or less than 2 percent.

The illustrative Medicaid expansion would raise national health expenditures by about the same amount as the employer mandate.

SUMMARY TABLE 4. NATIONAL HEALTH EXPENDITURES BEFORE AND AFTER ENACTMENT OF ILLUSTRATIVE OPTIONS (In billions of 1991 dollars)

Source of Insurance	Expenditures Before Enactment	Changes in Expenditures Resulting from Enactment of: Employer Mandate	Medicaid Expansion	Combination
Total	740	13	13	20
Private Insurance	238	31	-3	29
Employment-Based	222	35	b	35
Employer share[a]	184	26	b	26
Employee share	38	9	b	9
Other	17	-5	-3	-6
Government	321	-8	26	9
Medicare	123	-4	b	-4
Medicaid	92	-2	29	18
Other	106	-3	-3	-5
Other	180	-9	-10	-18
Direct patient	149	-9	-10	-18
Other	31	b	b	b

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration.

a. Includes premium payments by federal, state, and local government agencies on behalf of government employees.

b. Less than $500 million.

It would, however, have very different distributional effects. Medicaid spending would increase by about $29 billion--an increase of more than 30 percent above 1991 levels. Other spending would fall by about $16 billion--the result of a $3 billion reduction in premiums for individually purchased insurance, a $3 billion decrease in state spending on indigent care, and a $10 billion drop in direct spending by the previously uninsured.

The illustrative combination option would increase national health expenditures by more than either the employer mandate or the Medicaid expansion alone--by $20 billion, or just under 3 percent of national health expenditures. This amount would be the net result of a $53 billion increase in spending on Medicaid and employment-based insurance offset by a $34 billion reduction in other spending.

Advantages and Disadvantages

All three illustrative options share the basic advantage of covering a majority of the uninsured by expanding existing institutional arrangements, but they differ somewhat in their other advantages and in their disadvantages.

The principal advantage of the employer mandate is its minimal effect on the federal budget deficit--roughly $1.8 billion compared with $16.4 billion for the Medicaid expansion. The employer mandate's major disadvantage is its potential effect on employment, because mandating coverage would raise labor costs for affected firms and workers. Some employers might lay off workers or reduce the hours of those who remained employed to below the mandated threshold for coverage. Affected the most would be small firms, which employ over half of all uninsured workers. Exemptions for small firms would protect them, but would also reduce the effectiveness of this approach in expanding coverage. Subsidies for small businesses would mitigate this problem, but they would increase the federal deficit. In addition, enforcing the employer mandate would be administratively difficult, especially for industries where workers changed jobs frequently or had frequent spells of unemployment. Finally, an employer mandate would limit the choices of firms and workers.

The principal advantage of expanding Medicaid would be that all additional federal and state spending would be concentrated on individuals who are least able to afford private coverage--those with family incomes below 200 percent of poverty. A major disadvantage of expanding Medicaid would be its effect on federal and state spending--an increase of about $16 billion and $12 billion in 1991, respectively, under the illustrative option. State governments already face higher outlays as a result of federally legislated Medicaid expansions that were enacted during the 1980s. Taxes would have to be increased or other spending reduced significantly at both the federal and the state level to pay for further expansions.

In addition, expanding Medicaid would also be administratively complicated, involving means-testing of many more people. Moreover, because Medicaid's reimbursement rates are lower than most other payers, the new beneficiaries might find that their access to care was still restricted. Finally, a major Medicaid expansion would create incentives for employers with high proportions of low-wage workers to drop their health plans.

The illustrative combination option would have most of the advantages of the illustrative employer mandate and Medicaid expansion options. It would have an important advantage compared with the Medicaid expansion--firms with high proportions of low-wage workers would not be allowed to drop their health plans. This approach would provide coverage for almost all the uninsured--as few as 5 million people would remain uncovered--and all the poor would be covered with minimum interference with existing insurance arrangements. Moreover, it would not increase the federal deficit as much as the stand-alone Medicaid expansion--but it would increase the deficit by more than the employer mandate alone.

The combined approach would also have many of the disadvantages of the employer mandate--potential reductions in employment for low-wage workers, adverse effects on small firms, and limits on choices for workers and firms. Although the Medicaid expansion under the combined approach would be limited to members of families without much connection to the labor force, it would have some of the disadvantages of the stand-alone Medicaid expansion--the program would still add substantially to federal and state expenditures and some beneficiaries might not gain easy access to health care.

CHAPTER I

INTRODUCTION

In March 1990, 33 million people in the United States did not have health insurance. For those finding themselves in this situation, a major medical episode can be a financial catastrophe as well as a personal one. Since most of the elderly have Medicare coverage, this problem is concentrated among nonelderly adults and children.

At a time of rapidly rising health expenditures, concern over international competitiveness, and large budget deficits, it is difficult to fashion acceptable methods of providing health insurance for the medically uninsured. This study analyzes two major approaches for substantially reducing the number of uninsured people. One would expand employment-based coverage, and the other would cover more people under Medicaid.

Interest in these two approaches has been considerable because employment-based and Medicaid coverage are major sources of health insurance for the nonelderly today. Therefore, expanding these sources, rather than creating new government programs, would be less disruptive to existing health insurance arrangements. Moreover, a substantial portion of the uninsured could be reached through either approach or through a combination of them. Four-fifths of the currently uninsured are workers or dependents of workers, and three-fifths of the currently uninsured are poor or near-poor.

This study is one in a series of recent Congressional Budget Office (CBO) analyses of issues related to rising health care costs and the uninsured. Two of these CBO studies examine trends in health spending over time, the impact of rapidly rising health care costs on the health insurance market, and the effectiveness of selected strategies to

control health spending.[1] In another analysis, CBO examined five options that would provide insurance to those who are currently uninsured.[2] This study of ways to expand employment-based insurance and Medicaid coverage provides greater detail on these approaches and their effects, but does not examine other major proposals for changing the health care system.[3]

The rest of this chapter provides background information on the uninsured. It first describes sources of health insurance coverage in 1990 and then examines post-World War II trends in coverage. Finally, the chapter looks specifically at the uninsured--who they are, why they are uninsured, and why being uninsured is a problem. The following chapters of this study analyze the three approaches in detail: requiring employers to provide coverage for their employees, expanding Medicaid, and combining these two policies. An appendix provides details on estimating procedures.

MAJOR SOURCES OF HEALTH INSURANCE

Health insurance is provided through a variety of public and private sources: employment-based group insurance, Medicare, Medicaid, the Department of Veterans Affairs (VA), and individually purchased policies. Despite all these sources, 33 million people, virtually all of them under age 65, do not have insurance. (Unless noted otherwise, "insurance" and "coverage" are used to denote "health insurance" and "health insurance coverage," respectively.)

---

1. Congressional Budget Office, "Trends in Health Expenditures by Medicare and the Nation," CBO Paper (January 1991); Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991).

2. See the testimony of Robert D. Reischauer before the House Committee on Ways and Means, April 23, 1991.

3. For an analysis of the implications of extending Medicare's payment rates in either an all-payer system or a single-payer system (both of which would cover the currently uninsured), see a forthcoming Congressional Budget Office report on the implications of extending Medicare's payment rates in these systems.

Employment-based Group Insurance

Employment-based group insurance is the most common source of insurance coverage. More than 150 million people under the age of 65, or about 70 percent of the nonelderly population, receive their primary coverage through this type of insurance (see Table 1). (The term primary coverage refers to the primary payer--that is, the payer that is obligated to pay for care before any liability of other, secondary insurers. Many people with employment-based health insurance also have other types of secondary coverage.) Typically, the employer offers to pay some, or all, of the premiums for workers and their dependents. The employees decide whether or not to accept coverage.

Employers can purchase insurance policies that cover their employees, or they can self-insure. State governments regulate the insurance that employers purchase, often mandating certain types of benefits or other terms of the policy. If an employer self-insures, federal regulations preempt state insurance regulations. Since federal regulations are less restrictive, large employers generally self-insure, although many firms contract with a third-party administrator (TPA)--which is often a private insurance company--to administer their health plans.

Public Programs

About 45 million people, or 18 percent of the U.S. population, have coverage through the public sector (see Table 2). Medicare--the primary payer--provides most of this coverage. In fact, more than 90 percent of the elderly have Medicare as their primary payer. About 18 million, or about 8 percent of the nonelderly, have publicly provided coverage.

Medicare. Medicare is the principal insurance program for the elderly. More than 27 million, or 93 percent of the elderly, receive primary coverage through this program, which also covers nonelderly, disabled people. (Another 3 percent of the elderly have secondary coverage through Medicare, but are classified in Table 1 under their primary source--employment-based coverage.)

Medicare consists of two separate programs. The Hospital Insurance (HI) program provides basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over; individuals under age 65 who have been entitled to Social Security disability benefits for at least 24 months; and certain other individuals who have end-stage renal disease. Supplementary Medical In-

TABLE 1. SOURCE OF INSURANCE COVERAGE FOR THE UNITED STATES POPULATION, BY AGE, 1990

Source of Insurance	Total	Age		
		0 to 17	18 to 64	65 and Over
	People (Millions)			
Employment-Based	152.3	46.6	104.0	1.6
Medicare	30.5	0.0	2.9	27.5
Medicaid	14.6	8.0	6.6	0.0
Veterans Affairs	0.8	0.0	0.8	0.0
Other private	14.7	1.2	13.4	0.1
None	33.4	8.5	24.5	0.3
Total	246.2	64.3	152.3	29.6
	Percentage of Age Group			
Employment-Based	61.8	72.4	68.3	5.5
Medicare	12.4	0.1	1.9	92.9
Medicaid	5.9	12.4	4.3	0.0
Veterans Affairs	0.3	0.0	0.5	0.1
Other private	6.0	1.9	8.8	0.4
None	13.6	13.3	16.1	1.0
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

NOTE: In general, people covered by more than one source of insurance are classified by the primary source. For example, retired elderly Medicare beneficiaries are classified there, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. In contrast, the working aged, whose plans are primary payers to Medicare, are classified under employment-based coverage.

surance (SMI), a voluntary insurance program for aged and disabled individuals who elect to enroll, provides insurance benefits for physicians' and other medical services. The premium payments of enrollees finance roughly one-fourth of the SMI program's costs; the balance is provided from general appropriated funds of the federal government. Virtually all--95 percent of the elderly--enroll in SMI.

Medicaid. Medicaid is a federal/state entitlement program that pays for medical benefits and long-term care to people whose incomes and resources are insufficient to pay for health care and who meet certain categorical requirements--for example, being aged, blind, disabled, members of families with dependent children, or pregnant. Title XIX of the Social Security Act provides matching federal funds that finance between 50 percent and 80 percent of a state's Medicaid spending in 1991. Almost 15 million, or 7 percent, of the nonelderly have Medicaid as their primary payer.

Military Programs. Several public programs serve current and former members of the armed services and their families. About 800,000 veterans receive their primary care through the Department of Veterans Affairs. Another 3.6 million retired and active-duty military and their dependents receive medical care through military hospitals and an insurance program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). (People who receive their primary health insurance coverage through the military hospitals and CHAMPUS are classified as "employment-based" in Table 1.)

Other Private Insurance

About 15 million people, or 7 percent of Americans under 65, have private insurance policies that are not provided by employers. Many of these policies appear to represent limited coverage of one type or another. For example, some people have "dread disease" insurance that provides limited benefits for specific diseases, and others have accident or disability insurance. Some people purchase individual policies, however, with comprehensive major medical coverage. (Comprehensive major medical coverage refers to an insurance policy designed to give the protection offered by both a basic and a major medical health

insurance policy. It is characterized by a low deductible amount, a coinsurance feature, and high maximum benefits.) Privately purchased, nongroup policies usually have much higher loading, or administrative, costs than is typical for most group policies. Loading costs for firms with more than 100 employees range from 6 percent to 16 percent of premiums; for individual health insurance, they are as high as 40 percent. Thus, people with this type of insurance pay more, on average, for the same degree of coverage.

TRENDS IN INSURANCE COVERAGE

Insurance coverage grew during the first three decades after World War II Since the mid-1970s, however, coverage has not expanded and actually declined slightly during the past decade.

Major Trends Since World War II

Both surgical and hospitalization insurance coverage grew rapidly after World War II. The proportion of the population with surgical coverage increased from about 25 percent in 1949 to about 70 percent in 1965; the proportion with hospitalization coverage increased from about 40 percent to 75 percent during the same period. In 1965, both Medicare and Medicaid were enacted, expanding insurance coverage for the elderly and the poor, two groups that previously had very limited access to insurance.

The rapid growth in insurance coverage slowed down after the Medicare and Medicaid expansions were completed, ending by the mid-1970s. In fact, insurance coverage--as measured by the proportion of the population insured--appears to have eroded somewhat during the 1980s. In 1978, 12.3 percent of people under 65 did not have insurance according to data from the Health Interview Survey (HIS), as shown in Table 2. By 1982, the percentage of uninsured had risen to 13.8 percent; it rose further to 14.8 percent by 1986, but has remained fairly steady since then. In 1989, 14.9 percent of the nonelderly were uninsured--an increase of 2.6 percentage points in the proportion of the population without insurance between 1978 and 1989.

This increase can be attributed to a decline in private insurance coverage--which fell from 79.6 percent in 1978 to 76.4 percent in 1989, offset by a modest increase in public coverage--which rose from 8.2 percent in 1978 to 8.7 percent in 1989. Data from the Current Population Survey (CPS) from 1980 to 1987 show a similar pattern. Those data indicate an increase of about 2.8 percentage points in the proportion of the nonelderly without health insurance, although most of that increase occurred during the 1982-1985 period. The CPS data also attribute most of the increase to a decline in private coverage.

TABLE 2. TRENDS IN HEALTH INSURANCE COVERAGE, 1978-1989

Source	1978	1980	1982	1984	1986	1989
			People (Millions)			
Private[a]	152.0	154.7	157.8	157.8	160.9	163.7
Public[b]	15.7	15.2	16.2	18.0	17.0	18.6
None	23.4	24.2	27.8	29.5	30.9	32.0
Total	191.0	194.0	201.7	205.2	208.8	214.3
			Percentage Distribution			
Private[a]	79.6	79.7	78.2	76.9	77.1	76.4
Public[b]	8.2	7.8	8.0	8.8	8.1	8.7
None	12.3	12.5	13.8	14.4	14.8	14.9

SOURCE: Estimates from Fu Associates, Arlington, Virginia. Based on the Health Interview Survey.

NOTE: Respondents with various responses that were categorized as "unknown" were included in either the "private" or "public" categories in proportion to their share of the responses among those with known coverage. More specifically, 90.6 percent were assigned to private and 9.4 percent were assigned to public.

a. Any private coverage. Respondents with both private insurance and public coverage were included in this category.

b. Public coverage only.

Underlying Causes

The increase in the proportion of people without insurance during the 1980s was not expected and is not easy to explain. Two possible causes for the decline in employment-based insurance are changes in the unemployment rate and a shift from manufacturing to service jobs. Neither explanation, however, explains that drop very well.

The level of unemployment rose from 7.0 percent in 1980 to 9.5 percent in 1982. During this period, the uninsured increased from 12.5 percent of the nonelderly population to 13.8 percent. The percentage of uninsured did not fall, however, when the economy recovered. In fact, 14.9 percent were uninsured in 1989 when the unemployment rate was 5.2 percent.

A shift in the type of jobs that workers hold also does not adequately account for the drop in insurance coverage. Such a shift is a very gradual process, whereas the decline in insurance coverage was relatively quick and appears to have leveled off since 1986. Similarly, examination of data from the Current Population Survey suggests that industry shifts in employment accounted for less than 15 percent of the total increase in uninsured workers during the 1980-1987 period. Instead, insurance coverage appears to have fallen in all industries. In other words, either companies accounting for a smaller share of employment within each industry are offering insurance coverage or more workers are declining coverage. Both possibilities could be related to the rapid escalation of health care costs.

THE UNINSURED

In order to design policies to deal with the uninsured, it is important to know who they are, why they are uninsured, and what the consequences are of their lack of coverage.

Characteristics of the Uninsured

Certain people--young adults, the poor and near-poor, and adults and children in families without a worker--are more likely than the average person to be uninsured.

Young adults (those between 18 and 24 years of age) are much more likely to be uninsured--25.1 percent compared with the average rate of 13.6 percent in 1990 (see Table 3). In fact, 20.9 percent of all adults under the age of 35 were uninsured. By contrast, adults over the age of 35 are more likely to be insured--for example, only 10.1 percent of men between the ages of 55 and 64 were without insurance that year. Because of Medicare, only 1 percent of the elderly were uninsured in 1990.

Family income (measured as a percentage of the family's poverty threshold) is also closely related to whether or not people have insurance. More than 30 percent of poor people (those with family incomes below the poverty level) and 23 percent of near-poor people (those with incomes above the poverty level but below 200 percent of it) were uninsured. By contrast, about 6 percent of those whose family incomes were at least 300 percent of the poverty level lacked insurance.

The maximum hours worked by the head of household or spouse is also related to the likelihood of being uninsured. More than one-fourth of all people in families with at least one worker who worked fewer than 35 hours per week were uninsured. By contrast, only 11.9 percent of those in families with at least 35 hours were uninsured. Because most families contain at least one full-time worker, however, almost 60 percent of the uninsured are in households with at least one full-time worker.

Being insured is related to the type of family unit in which an individual resides. The most likely to be uninsured are adults and children living in single-parent families--21.8 percent were uninsured.

TABLE 3. CHARACTERISTICS OF THE UNINSURED, 1990

Characteristic	Number (Millions)	Uninsured as a Percentage of Category	As a Percentage of All Uninsured
All Uninsured	33.4	13.6	100.0
Age and Sex			
Children	8.5	13.3	25.6
Young Adults, 18 to 24	6.4	25.1	19.0
Women			
25 to 34	3.3	15.3	10.0
35 to 44	2.1	11.4	6.4
45 to 54	1.7	12.7	4.9
55 to 64	1.5	13.0	4.4
Men			
25 to 34	4.6	21.4	13.8
35 to 44	2.5	13.7	7.5
45 to 54	1.5	12.1	4.5
55 to 64	1.0	10.1	3.0
Elderly, 65 and over	0.3	1.0	0.9
Family Income as a Percent of Poverty (1989)			
Below 100	9.6	30.2	28.8
100 to 199	10.6	23.3	31.8
200 to 299	5.9	13.0	17.7
300 or higher	7.2	5.9	21.7
Maximum Hours by Family Worker[a]			
None	8.8	14.4	26.3
1 to 24 hours	2.0	26.3	6.1
25 to 34 hours	2.7	25.8	8.1
35 or more	19.9	11.9	59.5
Race			
White	25.9	12.5	77.5
Black	5.8	19.2	17.5
Other	1.7	19.1	5.0
Family Structure			
Unrelated individual	6.0	16.9	17.9
Single-parent family	9.1	21.8	27.2
Two-parent family	15.7	12.3	47.1
Childless couple	2.6	6.3	7.8

(Continued)

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

TABLE 3. Continued

Characteristic	Number (Millions)	Uninsured as a Percentage of Category	As a Percentage of All Uninsured
Major Activity			
Working	14.9	13.8	44.5
Looking for work	1.2	41.5	3.5
Keeping house	4.0	13.2	11.9
In school	2.9	16.5	8.7
Unable to work	0.4	11.5	1.3
Retired	0.5	2.8	1.5
Other	2.5	21.9	7.5
Child under 18	7.0	12.7	21.1
Family Work Status[b]			
Employed	26.8	13.9	80.2
Unemployed	2.0	31.9	6.1
Not in labor force	4.6	9.8	13.7
Marital Status			
Married, spouse present	9.5	8.9	28.5
Separated	1.7	27.3	5.0
Divorced	3.0	19.7	8.9
Widowed	0.9	6.6	2.7
Never married	9.8	24.2	29.3
Child under 18	8.5	13.3	25.6
Census Division			
New England	1.1	8.9	3.4
Middle Atlantic	4.0	10.6	12.0
South Atlantic	6.2	14.5	18.4
East North Central	3.9	9.4	11.8
East South Central	2.2	14.6	6.6
West North Central	1.7	9.7	5.1
West South Central	5.5	20.9	16.6
Mountain	2.0	14.9	6.0
Pacific	6.7	17.4	20.1

a. Hours worked last week by head or spouse, whichever is greater. Nonstudents who were 19 or older and students who were 24 or older are treated as separate individuals in this calculation. For that reason, the 8.8 million people with no hours of work include 2.2 million people who live in families where the head or spouse work but who were not included in the family.

b. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head nor spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

292-891 0 - 91 - 3

Although only 12.3 percent of members of two-parent families were uninsured in 1990, this group--again because of its large size--made up 47.1 percent of all the uninsured.[4]

Why Are Some People Uninsured?

Since most people are insured through employers, access to employment-based insurance is the most important factor that determines whether or not people are insured. Nonelderly adults who are out of the labor force or who are unemployed for a lengthy time usually have to find another source of insurance for themselves and their dependents.

Almost a quarter of workers were not offered insurance by their employer in 1988 (see Table 4). These workers also had to find another source of insurance for themselves and their dependents. In addition, some workers--about 4 percent--turned down insurance through their own job because they were covered by their spouse's employer. Another 5 percent, however, turned down insurance through their own job and were not covered through their spouses' plans. As discussed previously, about four-fifths of the uninsured live in a household where the head or spouse is employed.

For those without any attachment to the labor force, the primary source of insurance is public programs, but they are available only for certain specific categories of people. In addition to being poor, to be eligible an individual must be either old, disabled, pregnant, or a member of a certain type of family unit.

Those who are not offered employment-based coverage and who are not eligible for public programs have several difficulties purchasing private individual policies. First, individually purchased insurance is expensive both because of the high "loading" and because the premium is not shared with an employer. Second, people in poor

4. For a much more comprehensive description of the characteristics of the uninsured based on the March 1990 CPS, see Jill D. Foley, "Uninsured in the United States: The Nonelderly Population without Health Insurance," Employee Benefit Research Institute (April 1991).

TABLE 4. EMPLOYERS' OFFERS OF HEALTH INSURANCE AND EMPLOYEES' RESPONSES, 1988

Category	Number of Employees (Millions)	Percentage of All Employees
All Employees	105	100
Employer Offered Insurance to Employee	79	76
Employee enrolled	69	66
Turned down, covered by spouse's employer	4	4
Turned down, not covered by spouse's employer	6	5
Employer Did Not Offer Insurance to Employee	26	24
Firm offers insurance, but employee is ineligible	6	6
Firm does not offer insurance	19	18

SOURCE: Congressional Budget Office estimates based on the May 1988 Current Population Survey.

health (substandard risks) have trouble obtaining insurance, or else must pay considerably higher rates for their coverage.[5]

Consequences of Being Uninsured

Lack of health insurance has serious consequences for the uninsured themselves who face both access and financial problems when they need care; for the hospitals, doctors, and other providers that treat the uninsured; for businesses and their employees that must pay higher premiums to subsidize the uninsured; and for all levels of government that pay for much of the care of the uninsured indigent population.

5. For a more complete discussion of reasons for lack of health insurance, see Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991), Appendix B.

The core of the problem for the uninsured is financial--they must pay for their own health care, find someone else to pay, or forgo health care services. The uninsured have been estimated to use 37 percent less physician services and 69 percent less hospital services compared with the insured population.[6] On the one hand, these differences may reflect a reduction in medical care of low marginal value. On the other hand, many of the uninsured may fail to get important preventive care such as prenatal care in the early months of pregnancy and well-baby care after delivery.

A recent study, for example, found that people without insurance are less likely to be given routine diagnostic tests, less likely to undergo key surgical procedures, and more likely to die during their stay in a hospital than those with similar health status who had private insurance. Specifically, the study found that the uninsured were 74 percent less likely to get a total knee replacement, 45 percent less likely to get a hip replacement, and 29 percent less likely to get coronary bypass surgery compared with insured patients. Finally, the study estimated that uninsured hospital patients were 1.2 to 3.2 times more likely to die than were insured patients.[7]

The estimated $10.7 billion of uncompensated care in 1988 was an important financial strain for hospitals, county governments, and possibly businesses as well. Although this cost represents 2 percent of spending on personal health care, it is concentrated among certain providers--mainly hospitals that serve a disproportionately large share of poor patients.

Many business leaders are concerned about the costs of caring for the uninsured because they believe that the costs are "shifted" to the insured through higher charges for health care services. The move, however, toward greater use of negotiated payment arrangements, particularly through preferred provider organizations (PPOs), has

---

6. Stephen H. Long and Jack Rodgers, "The Effects of Being Uninsured on Health Care Service Use Estimates from the Survey of Income and Program Participation," Survey of Income and Program Participation (SIPP) Working Paper No. 9012, Bureau of the Census (October 1990).

7. See Jack Hadley, Earl P. Steinberg, and Judith Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *Journal of the American Medical Association*, vol. 265, no. 3 (January 16, 1991), pp. 374-379.

tended to reduce the ability of hospitals to shift the cost of treating the uninsured to those with insurance. But as cost shifting becomes more difficult, there may be a further reduction in access to care for the uninsured.

CHAPTER II

ANALYSIS OF OPTIONS THAT WOULD EXPAND EMPLOYMENT-BASED HEALTH INSURANCE

If the Congress mandated that employers provide health insurance coverage for some or all of their current or former employees and their dependents, the number of the uninsured would be substantially reduced, because about four-fifths of the uninsured are workers or dependents of workers.

The analysis of the approaches examined in this chapter contains a number of limitations. First, most of the discussion of the employer mandate is restricted to an illustrative plan that would affect a specific subset of employees and firms. Although this method of analysis limits its generality, it allows the analysis to be more concrete and the results to be quantified. Moreover, a later section examines variations in the key assumptions to show how they affect the analysis.

A second limitation is that the analysis does not account for potential changes in behavior, such as changes in employment conditions. For example, an employer mandate could result in loss of jobs for some workers and changes in hours of work for others. Another secondary effect that is not accounted for is the increase in inflation that might result from putting more spending in the health care sector. Although potentially important, these effects are probably smaller in magnitude than the primary impacts on health care coverage and spending. Although CBO has not done a formal estimate of the effect on employment of mandating employment-based insurance coverage, the loss would probably be in the range of 50,000 to 100,000 jobs, or less than one-tenth of 1 percent of the labor force.[1] The inflationary effect also would probably be modest. As shown below, an employer mandate would increase total health spending by less than 2 percent.

1. See the testimony by Edward M. Gramlich before the Committee on Labor and Human Resources of the U.S. Senate, November 4, 1987.

AN ILLUSTRATIVE MANDATED HEALTH INSURANCE OPTION

This illustrative option would require employers to provide insurance to employees and their dependents. More specifically:

- All employers with 10 or more employees, including governments, would have to offer a qualified insurance plan to employees who worked 25 hours or more per week and to these employees' dependents;

- Dependents, other than spouses, would have to be covered through age 18 (age 23 for full-time students);

- Employers would have to pay at least 75 percent of the premiums;

- Eligible employees would be required to accept the coverage and pay 25 percent of the premiums;

- Working spouses might be covered by their own or their spouses' plans at the employees' discretion, but would have to be covered by at least one of them;

- Children might be covered by either spouse's plan at the employee's discretion, but would have to be covered by at least one of them;

- Employers would have to provide benefits actuarially equivalent to a minimum plan: a single annual deductible of $250 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $875. These provisions, which would cost about $2,900 for a family in 1991, would be more generous than the plans currently provided to the 10 percent of employees with the least adequate coverage; and

- Firms with fewer than 25 employees (but at least 10) would be required to purchase their insurance through an insurance pool. The pool would provide a choice of health insurance plans, the least adequate of which would meet the requirements of the minimum plan. Premiums would be based on a community rating. (Community rating is a method of establishing premiums for health insurance in which the premium is based on the average cost of actual or anticipated health care used by all subscribers in a specific geographic area. It does not vary for different groups or subgroups of subscribers or with such variables as the group's claims experience or health status.)

The specifications of the illustrative option are designed to minimize disruptions in current insurance and work arrangements. Letting working spouses be covered through their own employers or through their spouses' employers would reduce the number of people who would have to change insurers. Similarly, letting children be covered through either employer would also reduce the number of changes in insurance coverage. Finally, letting firms choose the specific benefits of their plans--within limits defined by the actuarial equivalence test--would mean that most current insurance policies would not have to be modified.

The requirement that small firms join a pooling arrangement would assure moderately priced insurance plans for all small businesses. In the current marketplace for small group insurance, loading costs for firms with fewer than 20 employees averages from 30 to 40 percent of premiums. Moreover, small firms are unable to spread the cost of seriously ill employees over a large pool of healthy employees. For these reasons, small businesses may have insurance premiums that are extremely high. Under the pooling arrangement, the high loading costs associated with marketing to small firms would be significantly reduced and all small firms in the community would share the cost of sick employees.

TABLE 5. WORKERS AND DEPENDENTS AFFECTED BY AN ILLUSTRATIVE EMPLOYER MANDATE (In millions)

Coverage Category	Workers	Dependents	Total
Total Number Affected[a]	15.0	15.6	30.6
Previously Uninsured	8.8	8.7	17.6
Previously Insured by Nonemployer Source	6.1	6.9	13.1
Medicare	0.8	0.9	1.7
Medicaid	0.8	2.0	2.8
Veterans Affairs	0.3	0.1	0.4
Other private	4.3	3.9	8.2

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

a. An additional 3.1 million workers who already have group coverage would have to insure one or more dependents who are not covered under employment-based plans. These workers are not shown in this table as being affected by the illustrative mandate, but their newly insured dependents are counted.

AN ANALYSIS OF THE ILLUSTRATIVE OPTION

Mandating that all employers with 10 or more employees provide coverage for their employees would potentially cover more than half of the currently uninsured. It would also affect workers, national health expenditures, firms, the U.S. economy in general, and federal, state, and local budgets.

Effects on People

If it had been fully carried out in 1991, this illustrative option would increase the number of people covered under employment-based plans by 30.6 million, of whom 17.6 million would otherwise have been uninsured (see Table 5).[2] In other words, this option would cover more than

2. The estimates of people affected by the options in this chapter are based on the March 1990 Current Population Survey. Although the U.S. population has been growing at an annual rate of 1 percent, certain demographic groups may change at a faster rate. For example, the current recession may have added up to a million uninsured people--an increase of 3 percent.

half of the currently uninsured, or roughly two-thirds of the uninsured who are connected to the labor force. Although 26.8 million, or 80.2 percent, of the 33.4 million uninsured live in a family in which someone works, 17.6 million, or 52 percent, meet the requirements of the illustrative option. To do that, they must live in a family in which a worker is employed 25 hours or more per week by a firm with 10 or more employees. In addition, dependents other than spouses must be under 19 years old (under 24 years old in the case of full-time students).

The other 13.1 million affected by the mandate for employers would have been previously insured through a public program or through an insurance policy purchased individually rather than through an employer. Some 1.7 million people currently covered under Medicare, and another 2.8 million people currently under Medicaid, would be required to participate in employment-based plans. By law, the employment-based plan is the primary payer for someone who has both an employment-based plan and either Medicare or Medicaid coverage. The public programs, as secondary payers, would be responsible for care not covered by the private plan. The mandate, however, would require workers newly eligible for employment-based group insurance to pay up to 25 percent of their private insurance premiums.

Finally, 8.2 million people who would acquire employment-based coverage already have individual policies. Because individual policies tend to be relatively expensive and their benefits would generally overlap with those of the new employment-based policies, owners would drop most of their individual policies. Since these people would pay at most 25 percent of the new plans' premiums, the direct effect would be to improve their coverage and lower their cost.

The effects of the employer mandate on covered workers and their dependents would vary by age, sex, income, and other characteristics. Although more than half of all uninsured persons would receive coverage under this mandate, it would affect only 25.3 percent of uninsured women between 55 and 64 years of age, 37.5 percent of uninsured men between 55 and 64 years of age, and 17.0 percent of uninsured elderly (see Table 6). Fewer than two-fifths of the uninsured poor would gain coverage.

TABLE 6. CHARACTERISTICS OF THE UNINSURED BEFORE AND AFTER ENACTMENT OF AN ILLUSTRATIVE EMPLOYER MANDATE

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Mandate
All Uninsured	33.4	15.8	52.6
Age and Sex			
Children	8.5	3.5	59.1
Young Adults, 18 to 24	6.4	3.0	52.3
Women			
25 to 34	3.3	1.5	55.2
35 to 44	2.1	0.9	56.1
45 to 54	1.7	0.9	47.6
55 to 64	1.5	1.1	25.3
Men			
25 to 34	4.6	2.1	53.3
35 to 44	2.5	1.2	52.7
45 to 54	1.5	0.7	53.6
55 to 64	1.0	0.6	37.5
Elderly, 65 and over	0.3	0.3	17.0
Family Income as a Percent of Poverty (1989)			
Below 100	9.6	6.0	37.8
100 to 199	10.6	4.8	54.8
200 to 299	5.9	2.3	61.4
300 or higher	7.2	2.8	61.9
Maximum Hours by Family Worker[a]			
None	8.8	8.8	0.0
1 to 24 hours	2.0	2.1	0.0
25 to 34 hours	2.7	0.5	82.6
35 or more	19.9	4.5	77.2
Race			
White	25.9	11.9	54.1
Black	5.8	3.2	45.6
Other	1.7	0.8	54.4
Family Structure			
Unrelated individual	6.0	3.4	43.4
Single-parent family	9.1	5.1	43.3
Two-parent family	15.7	6.2	60.8
Childless couple	2.6	1.1	56.4

(Continued)

SOURCE: Congressional Budget Office estimate based on the March 1990 Current Population Survey.

TABLE 6. Continued

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Mandate
Major Activity			
Working	14.9	4.6	68.8
Looking for work	1.2	1.0	9.9
Keeping house	4.0	2.7	31.0
In school	2.9	1.7	42.5
Unable to work	0.4	0.4	13.8
Retired	0.5	0.5	5.3
Other	2.5	2.1	18.2
Child under 18	7.0	2.8	59.9
Family Work Status[b]			
Employed	26.8	9.2	65.6
Unemployed	2.0	2.0	0.0
Not in labor force	4.6	4.6	0.0
Marital Status			
Married, spouse present	9.5	3.6	61.9
Separated	1.7	1.0	39.5
Divorced	3.0	1.7	44.0
Widowed	0.9	0.7	23.8
Never married	9.8	5.3	45.5
Child under 18	8.5	3.5	59.1
Census Division			
New England	1.1	0.5	53.6
Middle Atlantic	4.0	2.0	50.0
South Atlantic	6.2	2.8	54.7
East North Central	3.9	1.9	50.4
East South Central	2.2	1.1	50.8
West North Central	1.7	0.8	54.4
West South Central	5.5	2.6	53.6
Mountain	2.0	1.0	50.3
Pacific	6.7	3.1	53.5

a. Hours worked last week by head or spouse, whichever is greater. Nonstudents who were 19 or older and students who were 24 or older are treated as separate individuals in this calculation. For that reason, the 8.8 million people with no hours of work include 2.2 million people who live in families where the head or spouse work but who were not included in the family.

b. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head nor spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

Obviously, people who are attached to the work force would be affected to a much greater extent than those who are not. About 80 percent of uninsured people living in families where either the head or spouse works 25 hours or more each week would gain coverage. The other 20 percent live in households where the worker or workers are employed by firms with fewer than 10 employees--that is, their employers would be exempt from the mandate. The mandate would not affect uninsured people who are looking for work, keeping house, in school, unable to work, retired, or otherwise not in the labor force, unless they are the spouse or dependent of an affected worker.

Effects on Health Spending

Under this version of mandated health insurance, the total amount of health care spending in the nation would increase by about $13 billion--an increase of 1.7 percent above its 1991 level (see Table 7). This relatively small increase in national health spending would stem from two factors. First, more than 40 percent of those who would get new employment-based policies already have some type of insurance coverage--for them, the employer mandate would represent a switch from one type of coverage to another. Second, the currently uninsured are using some health services. For that reason, the increase in their health spending would be less than the cost of the new coverage.

The relatively modest change in national health spending masks the net effect of a much larger redistributive impact of the option--an increase of $35 billion in employment-based premiums combined with a $22 billion reduction in spending for other private insurance premiums and health services by governments and individuals. Premiums for employment-based coverage would increase by about $35 billion--$34 billion for new coverage and $1 billion to upgrade existing policies to meet the minimum standard required under this option. Employers would initially pay 75 percent--or $26 billion--of the additional premiums, and workers would pay $9 billion. Spending on other private insurance policies--largely by individuals--would fall by $5 billion. Government spending on health care would fall by more than $8 billion--about $5 billion less for the federal government and about $4 billion less for state and local governments. Patients would pay $9 bil-

lion less in out-of-pocket costs. Interestingly, the reduction in out-of-pocket expenses would offset the $9 billion increase in premiums paid by workers. This offset is true, however, only in the aggregate. For example, a worker who is currently covered by Medicare would experience an increase in premiums with only a partially off-setting reduction in out-of-pocket expenses.

TABLE 7. NATIONAL HEALTH EXPENDITURES BEFORE AND AFTER ENACTMENT OF AN ILLUSTRATIVE EMPLOYER MANDATE
(In billions of 1991 dollars)

Source of Payment	Before Enactment	After Enactment	Change
Total	740	753	13
Private Insurance	238	269	31
Employment-based	222	257	35
Employer share[a]	184	210	26
Employee share	38	46	9
Other	17	12	-5
Government	321	313	-8
Federal	220	215	-5
Medicare	123	120	-4
Medicaid	52	51	-1
Other	44	44	b
State and local	102	98	-4
Medicaid	40	39	-1
Other	62	59	-3
Other	180	171	-9
Direct patient	149	140	-9
Other	31	31	b

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration.

a. Includes premium payments by federal, state, and local government agencies on behalf of government employees.

b. Less than $500 million.

Effects on Firms

Despite the apparently large price tag of $35 billion, the illustrative mandate would largely not affect most employers because they already offer insurance plans that exceed the actuarial value of the mandated plan. At most, they might be required to pay premiums for a small share of their workers who would not purchase coverage for themselves or their dependents in the absence of a mandate.

In sharp contrast, employers that did not offer insurance to their workers before the mandate would, at least initially, experience large increases in their employee compensation costs--averaging about $1,900 per covered employee, or equivalent to roughly a 10 percent increase in the average wage rate. (The increase would be much larger for some employees. For example, for a full-time minimum wage worker with a family, the increase in compensation costs would be $2,900, or almost one-third.) Some employers might have trouble adjusting to the mandate in the short run.

This option would affect the workers who are concentrated in agriculture, construction, retail trade, and nonprofessional services industries. Although only 15.4 percent of all workers would acquire new coverage, about 25.6 percent of agricultural workers, 19.9 percent of construction workers, 19.0 percent of those in retail trade, and 20.5 percent of workers in other services would be newly covered through their employers (see Table 8 on pages 20 and 21). An estimated 24.0 percent of low-wage workers (those earning less than $5 per hour), and 32.1 percent of workers in firms with 10 to 24 employees would be affected.

Effects on the Economy

The immediate effect of the illustrative mandate would be to increase employers' costs for health insurance, if they did not already offer plans that met the minimum requirements or if their employees were not enrolling themselves or their spouses and dependents. If the affected employers did nothing in response, their profits would fall by the amount of their additional contributions. Over time, they would

try to raise the prices of their products or allow their employees' wages and fringe benefits to rise less rapidly than would have been the case had the mandate not been enacted.

Although the exact division among these alternatives is not known, employers would strive to minimize any impact on their profits. Because raising prices would reduce sales of their products, affected employers would adopt this strategy only to the extent that they could not shift costs to their employees. This shift could be accomplished over time by limiting wage increases, reducing fringe benefits other than health insurance, or cutting the quantity of labor employed. (In addition, because of the substantial turnover in low-wage jobs, employers could quickly start offering lower wage rates without actually reducing them for their current workers.) Workers would have little choice about accepting changes in the composition of their compensation, because all employers would generally behave in the same way. Moreover, since most of the workers who would be affected probably receive little or no compensation in the form of fringe benefits, the long-run effect would be to lower wages by about the amount of employers' required contributions.

For low-wage workers, though, it would take a long time before forgone wage increases would fully offset the cost of insurance. Moreover, employers covered by the minimum wage are forbidden by law to pay less to new workers. Finally, since the fringe benefits currently offered to minimum wage workers are so low relative to insurance premiums, changing them would provide little additional flexibility for employers.

The increased cost of employing low-income workers could, in turn, cause some firms to lay off some of them, reduce their hours, or hire fewer of them to replace those who resigned. Also, to avoid providing insurance, employers could recast some full-time jobs as 24 hours per week or less. These adverse effects on employees and employers might diminish over time if the minimum wage were not raised in concert with inflation and productivity growth in these jobs.

TABLE 8. CHARACTERISTICS OF WORKERS AFFECTED BY AN ILLUSTRATIVE EMPLOYER MANDATE

Characteristic	All Workers (Millions)	Percentage of Group Affected	Group As a Percentage of Affected
All Workers	117.3	15.4	100.0
Industry			
Agriculture	3.2	25.6	4.5
Construction	7.5	19.9	8.3
Finance	8.1	13.3	5.9
Manufacturing	20.8	12.9	14.9
Mining	0.7	12.1	0.5
Public administration	5.6	9.1	2.8
Retail trade	19.6	19.0	20.6
Services			
Professional	25.4	13.0	18.3
Other	13.6	20.5	15.4
Transportation	8.0	12.0	5.3
Wholesale trade	4.5	13.9	3.5
Other	0.2	a	a
Hourly Wage Rate (1990)			
Below $5.00	17.9	24.0	25.1
$5.00 to $9.99	47.4	17.8	49.4
$10.00 to $14.99	27.6	9.6	15.4
$15.00 or more	24.4	7.1	10.1
Firm Size			
Under 10 employees	15.9	0.0	0.0
10 to 24	18.9	32.1	33.5
25 to 99	15.3	21.9	18.5
100 to 499	16.3	16.7	15.1
500 to 999	6.6	13.0	4.8
1,000 or more	44.2	11.5	28.2
Family Income as a Percent of Poverty (1989)			
Below 100	6.5	39.8	14.4
100 to 199	15.6	28.4	24.5
200 to 299	20.5	17.7	20.1
300 or higher	74.6	10.0	41.0

(Continued)

TABLE 8. Continued

Characteristic	All Workers (Millions)	Percentage of Group Affected	Group As a Percentage of Affected
Age			
14 to 24	18.9	19.2	20.1
25 to 34	33.7	16.2	30.1
35 to 44	30.2	12.3	20.5
45 to 54	19.6	14.2	15.4
55 to 64	11.4	15.1	9.5
65 and over	3.5	22.5	4.4
Sex			
Male	63.6	16.0	56.1
Female	53.6	14.8	43.9
Race			
White	101.6	14.5	81.5
Black	11.8	21.9	14.3
Other	3.9	19.7	4.2
Census Division			
New England	6.7	11.9	4.4
Middle Atlantic	17.7	13.2	12.9
South Atlantic	20.9	16.6	19.1
East North Central	19.9	12.2	13.4
East South Central	6.8	15.6	5.9
West North Central	8.9	15.5	7.6
West South Central	11.9	19.8	13.1
Mountain	6.2	16.3	5.6
Pacific	18.3	17.9	18.2

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

a. Less than 0.05 percent.

In addition to the overall reduction in the number of full-time, low-wage jobs, employment would shift from the nonhealth sector to the health care sector of the economy. Because some workers would have less take home pay (after paying for the new insurance coverage through wages that would grow more slowly), spending on nonhealth goods and services would fall leading to lower employment in those sectors of the economy. In contrast, employment in the health care sector would rise as a result of spending $13 billion more for these services.

Effects on Federal, State, and Local Budgets

This option would probably result in a modest increase in the federal budgetary deficit--the net result of a loss in federal tax revenues partially offset by savings in Medicare and Medicaid outlays. The magnitude of the change is highly uncertain, however. Because this option would have broad consequences, quantifying the costs requires the use of a large number of assumptions, many of which are subject to substantial uncertainty. Also, these estimates are static and do not incorporate the macroeconomic effects discussed above or any resulting changes in revenues or in spending for programs such as Unemployment Insurance.

The estimated $1.8 billion increase in the federal deficit would be the net result of $4.6 billion in reduced spending for health services through public programs and $6.5 billion in reduced revenues as a result of the tax subsidy for employment-based health insurance (see Table 9). Federal outlays would drop because the new employment-based insurance benefits would substitute for some now provided through federal programs, such as Medicare and Medicaid. Achieving all of these savings would, however, depend on enforcing secondary payer provisions.

Medicare's outlays could be as much as $3.6 billion lower in 1991. This drop would occur because employment-based plans would be the primary payers for essentially all beneficiaries employed at least 25 hours a week. About 1.7 million Medicare beneficiaries and their spouses would acquire new employment-based insurance under the option, unless employers responded by hiring fewer workers age 65 and older or by hiring them for less than 25 hours a week.

Private plans would also become the primary insurers for 2.8 million individuals eligible for Medicaid, yielding federal savings of up to $1.1 billion. In addition, because the states pay about 43 percent of total Medicaid costs, they would save an additional $800 million.

Federal revenues would fall by roughly $6.5 billion--$3.0 billion less would be collected in personal income taxes and $3.5 billion less by the Social Security and Medicare payroll taxes. These revenue losses would be direct consequences of the differential treatment of wages and salaries--which are taxable--and of employers' contributions for employees' health benefits--which are not subject to either income or payroll taxes. The portion of the additional premiums that employees would pay directly would probably not affect revenues, since it would be paid from after-tax income. Although the estimates of revenue loss are based on the assumption that future wages would be lower than otherwise by the full amount of the premiums required of employers, the alternative assumption--that profits would be less by the full amount of the premiums required of employers--would generate

TABLE 9. EFFECTS ON THE FEDERAL BUDGET OF AN ILLUSTRATIVE EMPLOYER MANDATE
(In billions of 1991 dollars)

Budget Component	Effect
Federal Deficit	1.8
Outlays	-4.6
Medicare	-3.6
Medicaid	-1.1
Other	a
Revenue Loss	6.5
Individual income tax	3.0
Social Security and Medicare payroll taxes	3.5

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey and other sources.

NOTE: Negative outlays reduce the federal deficit, and positive revenue losses increase it.

a. Less than $500 million.

roughly the same amount of revenue loss. The difference between the two assumptions is that corporate income taxes would be lost under the latter one, while personal income taxes and Social Security taxes would be lost under the former one.

The illustrative employer mandate would reduce state and local spending and tax revenues. State and local governments would save almost $4 billion in outlays for Medicaid and indigent care. At the same time, their income tax revenues would decline by about $1 billion, for the same reason that the federal government would incur a reduction--wages and salaries are taxable, while employers' contributions for employees' health benefits are not. In the longer run, state and local sales and excise tax revenues would also tend to decline as spending shifted to medical goods and services, which are generally exempt from sales taxes, from other consumption goods on which taxes must be paid.

ALTERNATIVE SPECIFICATIONS

The illustrative option for mandated employment-based health insurance discussed above made specific assumptions about the threshold hours of work, size of firms included within the mandate, the level of the minimum benefit package, and rules for coordinating coverage. The estimated impacts of an employer mandate could be different if any of these characteristics were changed. This section examines the effects of varying these provisions.

Threshold Hours of Work

If the threshold for the mandate were set at some number of hours less than 25 hours per week, then an employer mandate would provide insurance coverage to more workers and dependents. Under the illustrative option, 30.6 million people--17.6 million of them previously uninsured--would receive new employment-based insurance and employers would initially have to pay $26.3 billion in additional premiums (see Table 10). On the other hand, if the threshold were lowered, for example, to 15 hours each week, then 34.7 million people would be

newly insured under an employment group--19.3 million of whom were previously uninsured--and the initial premium costs to employers would increase to $30.1 billion. On the other hand, if the threshold were increased to 35 hours, the number of newly insured would be 26.3 million--15.3 million of whom were previously uninsured--and employers would pay $22.4 billion more in premiums.

If the threshold for hours were set low, more workers and dependents would get coverage, but it could be very expensive for employers in the initial period after enactment, especially for employers with large numbers of low-wage workers. For example, the average cost for coverage for a half-time worker would be about $2 an hour, or 40 percent of wages if the worker earned $5 an hour, whereas at 40 hours a

TABLE 10. EFFECTS OF AN ILLUSTRATIVE EMPLOYER MANDATE UNDER DIFFERENT THRESHOLD HOURS OF WORK

	Minimum Hours for Full-Time Work		
	15	25	35
People Covered (Millions)			
Uninsured	19.3	17.6	15.3
Previously Covered by:			
Medicare	2.6	1.7	1.1
Medicaid	3.3	2.8	2.3
Other insurance	9.5	8.6	7.5
Total	34.7	30.6	26.3
Direct Cost (Billions of 1991 dollars)			
Employers	30.1	26.3	22.4
Employees	10.0	8.8	7.5
Total	40.2	35.1	29.9

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey and other sources.

week, coverage would cost about $1 an hour, or 20 percent of wages. Alternatively, a high threshold has the disadvantage that employers would have an incentive to create more part-time jobs. For example, if the threshold were set at a 35 hours a week, employers could avoid the $1,900 per employee cost of providing coverage by hiring more part-time workers for 34 hours a week.

Exemption of Small Firms

Businesses with certain characteristics--especially small businesses--are frequently exempted from federal regulations. Some exemptions are justified by the argument that the administrative burden of a particular regulation is too great for a small business. Other exemptions are justified by the argument that small businesses are financially weaker than larger firms.

Small firms would have several problems under an employer mandate. Even with a pooling arrangement like the one in the illustrative option, administrative costs would be higher for smaller firms. Moreover, the insurance pool would only partly reduce the high cost of premiums relative to wages for the small firms. Even if small firms faced the same premium as large ones, their costs would be higher relative to wages because wages are lower in small firms.

In recognition of these problems, small businesses could be given an exemption from the mandated insurance requirement. Alternatively, the exemption could serve as a substitute for the pooling arrangement in the illustrative options. If, as in the illustrative example, firms with fewer than 10 employees received an exemption, the number of people covered by the mandate would be 30.6 million--17.6 million of whom would be previously uninsured (see Table 11). If, instead, firms with fewer than 25 employees received an exemption, the number of people covered by the mandate would be 20.2 million--12.0 million of whom would have been previously uninsured--or a drop in newly covered people of about one-third. If the exemption were raised to 100 employees, the mandate would affect only 8.4 million of the 33.4 million uninsured--a drop in newly covered people of 52 percent com-

TABLE 11. EFFECTS OF AN ILLUSTRATIVE EMPLOYER MANDATE UNDER ALTERNATIVE EXEMPTIONS FOR SMALL FIRMS

	No Exemption	Exempt Firms Employing Fewer Than: 10	25
	People Covered (Millions)		
Uninsured	22.6	17.6	12.0
People Covered by:			
Medicare	2.2	1.7	1.0
Medicaid	3.3	2.8	2.1
Other insurance	11.1	8.6	5.0
Total	39.2	30.6	20.2
	Direct Cost (Billions of 1991 dollars)		
Employers	33.6	26.3	17.7
Employees	11.2	8.8	5.9
Total	44.8	35.1	23.6

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey and other sources.

pared with the illustrative option. Alternatively, if no exemption were allowed, 39.2 million people--including 22.6 million of the uninsured--or 28 percent more than under the basic illustrative option--would receive new employment-based insurance.

As an alternative to the exemption approach, all firms could be included in the mandate but small firms that have high premiums relative to payroll could be subsidized. For example, the federal government could pay any costs above, for example, 8 percent of payroll. This approach would, of course, increase the federal deficit.[3]

3. For a discussion of this type of approach see, Alain Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s (First of Two Parts)," *The New England Journal of Medicine*, vol. 320, no. 1 (January 5, 1989), p. 33.

Minimum Benefit Required Under the Mandate

Unless employers were required to provide some minimum level of health benefits under the mandate, they could fulfill the requirement by offering trivial benefits to their employees. Thus, the level of mandated benefits is an important consideration in designing an option that would embody this approach. The basic conflict is that requiring employers to provide a high level of benefits would assure that employees received adequate insurance, but higher benefits would add costs for employers that currently provide less generous plans.

Three levels of benefits are examined here--the illustrative option, one that would cost considerably less, and one that would cost more.

- Catastrophic Insurance. This plan would have a family deductible of $10,000--in other words, the family would receive no benefits until this annual deductible was met. It would cost about $1,000 in 1991 for family coverage.

- Illustrative Option. As noted earlier, this plan has a deductible of $250 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $875. It is more generous than the plan currently provided to 10 percent of employees and would cost about $2,900 for family coverage in 1991.

- Median Plan. This plan has a deductible of $125 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $450. It is more generous than the plan currently provided to 50 percent of employees with insurance coverage and would cost about $3,400 in 1991 for family coverage.

The catastrophic plan would have substantially lower premiums--only $11.8 billion for new coverage but negligible costs for upgrading current plans, since most employers already offer a richer insurance package--compared with a total of $35.1 billion under the illustrative option (see Table 12). In contrast, requiring all employers to provide the median plan would increase costs significantly--by $50.0 billion ($40.4 billion in new coverage and $9.6 billion for upgrading previous benefit packages).

Rules for Coordinating Coverage

Another issue related to which workers would be covered deals with how to treat other insurance coverage. Under the illustrative option, every employer would be required to cover all workers and their dependents only to the extent that they were not covered by other employment-based plans. Several alternative rules for dependents are possible, however, and the issues are somewhat different for working and nonworking dependents.

One alternative is to require that every employer cover all workers and their nonworking dependents without regard to other coverage--although the cost of covering someone who had other coverage (such as a child whose parents both worked full time) would generally be only about half that of a single source of insurance. Either approach would insure the same number of people who were previously uninsured, as well as the same number who had publicly provided or private nongroup insurance. The main difference is whether one firm would pay all the cost or whether two firms would split the cost.

TABLE 12. DIRECT COSTS OF AN ILLUSTRATIVE EMPLOYER MANDATE UNDER ALTERNATIVE LEVELS OF BENEFITS
(In billions of 1991 dollars)

Level of Benefits	New Coverage[a]	Upgraded Existing Coverage	Total
Catastrophic	11.8	b	11.8
Illustrative	34.2	0.9	35.1
Median	40.4	9.6	50.0

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

a. New coverage includes new employment-based insurance that replaces other private and government insurance programs as well as new coverage for the uninsured.

b. Less than $500 million.

Both approaches have certain advantages. On the one hand, the illustrative option would minimize changes in existing policies. Moreover, the number of people with duplicate coverage would be less than under the alternative approach.[4] On the other hand, the alternative would be easier to enforce compared with the illustrative option that would exempt certain workers. In addition, the alternative would eliminate the possibility that some employers might try to hire workers with other coverage at the expense of workers who did not have another source of insurance.

An intermediate approach would be to require that every employer cover every worker regardless of other coverage. Employers would be required to cover dependents only to the extent that other employment-based plans did not cover them. In this case, the dependents would be treated as they were under the illustrative option and workers would be treated as they were under the previous alternative. This approach would reduce the enforcement problems with regard to workers, but it would have the same problems as the illustrative option with regard to dependents.

ADVANTAGES AND DISADVANTAGES OF EMPLOYER MANDATES

Mandating employment-based insurance would be a mixed bag of pros and cons as a strategy for extending coverage to the uninsured. Noteworthy among the advantages is that if the illustrative option were used, a single policy action could cover more than half of the uninsured. In addition, this approach would build on existing institutional mechanisms for covering the working population and its dependents. Most workers would retain their current insurance, although some would add new beneficiaries to their existing policies.

---

4. Duplicate coverage under the alternative approach would also increase insurance costs somewhat for two reasons. First, administrative costs would be raised by processing additional enrollees. Second, some individuals will get slightly more coverage because their two insurance policies would have slightly different coverages. In this case, two $2,500 policies might have a value of $2,600, for example. One study estimated these additional costs at 20 percent--$2,500 and $3,000 in the above example. See Sheila R. Zedlewski, *Expanding the Employer-Provided Health Insurance System: Effects on Workers and their Employers*, Urban Institute Report 91-3 (Washington, D.C.: The Urban Institute Press, 1991), p. 58.

In addition, most people with individually purchased private insurance policies would obtain the advantages of employment-based coverage--that is, either lower premiums or greater benefits or both. A substantial number of Medicaid beneficiaries would obtain better access to care through employment-based policies because reimbursement rates for providers are usually higher under private plans than under Medicaid. Finally, if some of the costs of medical care for uninsured workers and their families are currently being shifted to insured workers through higher prices, then the employer mandate would redistribute these costs. In other words, the costs of medical care for workers and their families would be spread over a larger group of employers than is currently the case.

Because mandating health insurance would raise labor costs for affected firms and workers, the primary disadvantage of this approach is its potential for adverse effects on employment. Some employers might reduce their work force by laying off workers or by reducing the hours of those who remained employed. In addition to reducing the number of full-time workers, firms would have an additional incentive to restrict some workers to part-time work below the threshold in order to avoid the mandate altogether. This incentive would be particularly strong if a large proportion of a firm's workers were near the threshold set by the mandate.

Employers forced to provide health insurance for the first time would have an incentive to discriminate against workers with high insurance costs. For example, an employer would prefer to hire a married woman who is likely to be covered by her husband's more generous policy instead of hiring a single parent with children.

Another disadvantage of an employer mandate would be the adverse impact on small firms. Since small firms are primarily the ones that do not currently provide coverage, they are the ones that would bear the brunt of any policy that would expand employment-based insurance. Exemptions for small firms would protect them, but would also reduce the effectiveness of this approach in expanding coverage. Subsidies for small businesses would reduce the problem, but they would increase the federal deficit.

Enforcing the provisions of an employer mandate would be administratively complicated, especially for industries in which workers changed jobs frequently or had frequent spells of unemployment. Under the illustrative option, the employer would have to provide insurance to dependents whom another employer did not cover. How would the Department of Labor make sure that every dependent was covered by at least one employer? To complicate the task even further, certifying dependent coverage would have to be quite frequent. For example, a child could immediately lose coverage if the insuring parent became unemployed, dropped out of the labor force, or reduced hours of work below the minimum amount, even though the mandate would still cover the other parent.

Enforcing the provisions for firm size might also be difficult. Firms could fragment to avoid the mandate. For example, an eighteen-person firm could split into a sales force company with nine employees and a production company with nine employees. This hypothetical firm would then be exempt from the illustrative mandate which would exempt firms with fewer than 10 employees. Even if old firms could be kept from splitting, it would be impossible to monitor whether or not new firms were avoiding sizes of 10 or more.

Finally, an employer mandate would limit the choices of firms and workers. Firms would be required to offer health insurance coverage and workers would be required to accept it. To the extent that some people prefer to receive compensation in the form of wages, rather than insurance benefits, this option would reduce their well-being.

CHAPTER III

ANALYSIS OF OPTIONS THAT WOULD EXPAND MEDICAID

Almost one-fifth of the uninsured live in families in which no one is employed and another one-fourth live in families where none of the workers would qualify for the illustrative employer mandate discussed in Chapter II. Three-fifths of the uninsured, however, have family incomes below 200 percent of the federal poverty level. To address the problems of the low-income uninsured--regardless of labor force connection--the Congress could expand Medicaid to provide coverage for some, or all, of them.

In this chapter, the Medicaid expansion is compared with current law. The effects would be quite different if the Medicaid expansion were combined with an employer mandate. That option is examined in Chapter 4.

The analysis presented in this chapter is subject to a number of limitations. First, most of the discussion is restricted to an illustrative Medicaid expansion. A second limitation is that the analysis does not account for potential changes in behavior, such as changes in employment conditions. For example, employers with high proportions of low-income workers would be less likely to offer insurance coverage if they knew that most of their work force would be eligible for Medicaid. The estimates are also based on the assumption that everyone who is eligible for Medicaid coverage would accept it. Finally, the estimates show the effects of a Medicaid expansion as if it were put into place in March 1990. They do not reflect legislative changes that were put in place after that date, especially those under the Omnibus Budget Reconciliation Act of 1990.

AN ILLUSTRATIVE MEDICAID EXPANSION

The illustrative Medicaid option would:

- Expand Medicaid coverage to all individuals and families (without cost to them), regardless of their age or family circumstances, provided their family incomes were below 100 percent of poverty; and

- Allow individuals and families whose incomes are below 200 percent of the poverty level (but greater than or equal to 100 percent of the poverty level) to "buy in" to Medicaid based on a sliding scale of contributions, thereby avoiding any "notches" where a small increase in income would cause a substantial increase in the cost of participating. Specifically, the contribution or "premium" would be the smallest of the following:

  - Five percent of all family income above poverty for each covered family member; or,

  - Ten percent of all family income above poverty; or,

  - One-third of total costs of Medicaid coverage for an average family of this size and type.

- Maintain minimal copayments by beneficiaries as under current Medicaid rules.

Medicaid would continue to be a second payer to employment-based plans and to Medicare as under current law. In practice, Medicaid would replace individually purchased, private health insurance policies for eligible people because families with incomes below 200 percent of poverty would probably drop private policies with high premiums in favor of the premium-free, or highly subsidized, Medicaid coverage.

AN ANALYSIS OF THE ILLUSTRATIVE PLAN

Expanding the Medicaid program to cover everyone whose family income is below 200 percent of poverty could potentially provide health insurance for a majority of the currently uninsured. It would also have effects on national health expenditures and the federal deficit.

The estimates in this section are based on the assumption that everyone who is eligible would participate. Limiting the contribution to one-third of the actuarial value of the insurance benefits should encourage most eligible beneficiaries to participate. This conclusion is based on the observation that most workers accept their employers' coverage, even though they must make substantial contributions through premiums and copayments. In reality, however, some would probably choose to spend their limited incomes on other goods and services.

About 54 percent of those eligible for primary Medicaid coverage under this option would have to make a contribution. For many of these people, however, required contributions would be quite small--one-half would pay less than $25 per month and one-tenth would pay less than $5 per month. In fact, only about 12 percent of the contributions would be as high as one-third of the full actuarial value of the Medicaid coverage.

This option would greatly expand the Medicaid program, which would become the primary payer for up to 39.9 million Americans compared with its current estimated level of 14.6 million--an expansion of more than 170 percent in the number of noninstitutionalized people for whom Medicaid would be the primary payer (see Table 13).[1] These estimates include 700,000 uninsured children who will receive coverage in 1995 through the provisions of Omnibus Budget Reconciliation Act of 1990. Immediately establishing the illustrative option would provide health insurance coverage sooner for this group.

---

1. As was the case in the previous chapter, the estimates of people affected by the options in this chapter are based on the March 1990 Current Population Survey. The estimates are not adjusted to reflect population changes since March 1990.

The number of uninsured people would fall by up to 20.2 million--from 33.4 million to 13.1 million. In addition, 4.7 million people with individually purchased private policies and 300,000 people with VA coverage would become eligible for Medicaid. An additional 6.8 million people would receive new secondary coverage from Medicaid--4.3 million with employment-based policies as first payer and 2.5 million with Medicare as first payer (not shown in Table 13). Secondary coverage is assumed to be taken by families with incomes below the poverty level. Under this illustrative option, families above that level would not be offered the option of purchasing secondary coverage. Even if these families had the option, they would probably not choose to contribute up to one-third the actuarial value of primary Medicaid benefits for secondary Medicaid coverage.

The effects of the Medicaid expansion on the number of uninsured would vary by age and sex. Overall, the illustrative Medicaid program

TABLE 13. INSURANCE STATUS OF PEOPLE BEFORE AND AFTER ENACTMENT OF AN ILLUSTRATIVE MEDICAID EXPANSION (In millions)

Source of Insurance	Before Enactment	After Enactment	Change
Employment-Based	152.3	152.3	0.0
Medicare	30.5	30.5	0.0
Medicaid	14.6	39.9	25.3[a]
Veterans Affairs	0.8	0.5	-0.3
Other Private	14.7	10.0	-4.7
None	33.4	13.1	-20.2

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

NOTE: In general, people covered by more than one source of insurance are classified by the primary source. For example, retired elderly Medicare beneficiaries are classified there, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. In contrast, the working aged, whose plans are primary payers to Medicare, are classified under employment-based coverage.

a. This figure does not include 6.8 million people who would get new Medicaid second-payer coverage--4.3 million with employment-based policies as first payer and 2.5 million with Medicare as first payer.

would cover 60.6 percent of those uninsured in 1991 (see Table 14). Children and women of prime childbearing age (25-44), however, would be affected more than other groups. An estimated 74 percent of uninsured children and 64 percent of uninsured women, ages 25-44, would receive Medicaid coverage. Other age and sex groups would be affected less, but in each case the number of uninsured after the Medicaid expansion would be less than half its current level.

The principal difference between the Medicaid expansion and the employer mandate of Chapter II is that this option would provide coverage for the uninsured who live in families without employed workers. About 80 percent of such people would receive new Medicaid coverage. Under the employer mandate, none of this group would have been covered.

The net increase in spending on health care would be about $13 billion--an increase of 1.7 percent above its 1991 level (see Table 15). As explained in Chapter II, the increase in national health spending would be relatively small because the currently uninsured are using some health services. This massive expansion of Medicaid coverage, however, would increase government spending on that program by $29 billion in 1991--$16 billion in federal outlays and $12 billion in state outlays--an increase of more than 30 percent above 1991 spending at both levels of government. State and local governments would save about $3 billion in spending on indigent care for a net increase of $9 billion in state and local spending.

Nongovernment spending would fall by about $13 billion, however--the result of a $3 billion reduction in premiums for individually purchased insurance and a reduction of $10 billion in direct spending by the previously uninsured. As a result of new Medicaid coverage, beneficiaries who were previously uninsured would save $13 billion in direct out-of-pocket expenses offset by $3 billion in contributions under the buy-in--a net savings of $10 billion.

TABLE 14. CHARACTERISTICS OF THE UNINSURED BEFORE AND AFTER ENACTMENT OF AN ILLUSTRATIVE MEDICAID EXPANSION

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Medicaid
All Uninsured	33.4	13.1	60.6
Age and Sex			
Children	8.5	2.3	73.6
Young Adults, 18 to 24	6.4	2.9	55.0
Women			
25 to 34	3.3	1.2	64.3
35 to 44	2.1	0.8	63.0
45 to 54	1.7	0.7	59.4
55 to 64	1.5	0.6	58.8
Men			
25 to 34	4.6	2.3	50.5
35 to 44	2.5	1.2	52.8
45 to 54	1.5	0.8	48.7
55 to 64	1.0	0.4	57.4
Elderly, 65 and over	0.3	0.1	58.3
Family Income as a Percent of Poverty (1989)			
Below 100	9.6	0.0	100.0
100 to 199	10.6	0.0	100.0
200 to 299	5.9	5.9	0.0
300 or higher	7.2	7.2	0.0
Maximum Hours by Family Worker[a]			
None	8.8	2.2	74.5
1 to 24 hours	2.0	0.7	65.7
25 to 34 hours	2.7	0.9	67.2
35 or more	19.9	9.3	53.1
Race			
White	25.9	10.8	58.2
Black	5.8	1.6	72.4
Other	1.7	0.7	56.4
Family Structure			
Unrelated individual	6.0	1.9	67.4
Single-parent family	9.1	3.0	67.4
Two-parent family	15.7	6.8	56.5
Childless couple	2.6	1.4	46.3

(Continued)

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

TABLE 14. Continued

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Medicaid
Major Activity			
Working	14.9	7.5	49.7
Looking for work	1.2	0.4	61.7
Keeping house	4.0	1.1	72.0
In school	2.9	1.1	62.9
Unable to work	0.4	0.1	68.3
Retired	0.5	0.2	57.4
Other	2.5	0.9	66.2
Child under 18	7.0	1.8	74.0
Family Work Status[b]			
Employed	26.8	11.9	55.6
Unemployed	2.0	0.4	78.7
Not in labor force	4.6	0.8	82.1
Marital Status			
Married, spouse present	9.5	4.1	57.0
Separated	1.7	0.6	66.1
Divorced	3.0	1.2	60.3
Widowed	0.9	0.3	67.7
Never married	9.8	4.8	51.3
Child under 18	8.5	2.3	73.6
Census Division			
New England	1.1	0.7	38.0
Middle Atlantic	4.0	2.0	51.1
South Atlantic	6.2	2.4	60.2
East North Central	3.9	1.7	57.8
East South Central	2.2	0.6	73.7
West North Central	1.7	0.7	61.2
West South Central	5.5	1.5	72.5
Mountain	2.0	0.8	61.4
Pacific	6.7	2.8	57.8

a. Hours worked last week by head or spouse, whichever is greater. Nonstudents who were 19 or older and students who were 24 or older are treated as separate individuals in this calculation. For that reason, the 8.8 million people with no hours of work include 2.2 million people who live in families where the head or spouse work but who were not included in the family.

b. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head nor spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

TABLE 15. NATIONAL HEALTH EXPENDITURES BEFORE AND AFTER ENACTMENT OF AN ILLUSTRATIVE MEDICAID EXPANSION
(In billions of 1991 dollars)

Source of Payment	Before Enactment	After Enactment	Change
Total	740	753	13
Private Insurance	238	236	-3
Employment-based	222	222	b
Employer share[a]	184	184	b
Employee share	38	38	b
Other	17	14	-3
Government	321	347	26
Federal	220	236	16
Medicare	123	123	b
Medicaid	52	69	16
Other	44	44	b
State and local	102	111	9
Medicaid	40	52	12
Other	62	59	-3
Other	180	170	-10
Direct patient	149	139	-10
Other	31	31	b

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration.

a. Includes premium payments by federal, state, and local government agencies on behalf of government employees.

b. Less than $500 million.

ALTERNATIVE SPECIFICATIONS

The illustrative option discussed thus far would offer Medicaid coverage to everyone whose family income is below 200 percent of poverty but would require a contribution from everyone whose income is above the poverty threshold. This section shows how the effects would differ if selected key provisions of the illustrative option were changed.

Poverty Threshold

By altering the maximum family income threshold, the illustrative option could be expanded to cover more people or it could be narrowed to cover fewer. The illustrative expansion would provide Medicaid coverage for 25.3 million people at a federal cost of $16.4 billion in 1991 dollars (see Table 16). If instead coverage were limited to those with family incomes under 100 percent of poverty, 11.6 million could gain coverage, and federal costs would rise by $9.2 billion. In contrast, if the option were expanded to cover everyone with incomes up to 300 percent of the poverty level, 34.2 million people could become eligible at a federal cost of $20.3 billion (again assuming that all those eligible would choose to participate). The effects on state expenditures would be proportional to those on federal outlays.

Contribution by Beneficiaries

Two factors would affect the choice of contribution levels in any Medicaid expansion: the low incomes of the potential beneficiaries and the likely effects on participation rates of healthy people. Most of those receiving new Medicaid coverage under the illustrative option would have family incomes considerably below 200 percent of poverty. Under

TABLE 16. EFFECTS OF AN ILLUSTRATIVE MEDICAID EXPANSION UNDER ALTERNATIVE POVERTY LEVELS

Maximum Family Income (As a percentage of poverty)	People (Millions)	Federal Outlays (Billions of 1991 dollars)
100	11.6	9.2
150	19.0	13.4
200	25.3	16.4
300	34.2	20.3

SOURCE: Congressional Budget Office estimates based on March 1990 Current Population Survey.

current law, state Medicaid programs, which are allowed to collect co-payments, collect only minimal contributions from beneficiaries, some of whom have family incomes up to 185 percent of poverty. Thus, collecting substantial contributions from families with incomes in this range would be a major departure from current policy.

If everyone who was eligible chose to participate, near-poor beneficiaries would contribute about $2.6 billion to offset the cost of the illustrative Medicaid expansion, but several alternative approaches are possible. For example, if contributions were eliminated altogether, the costs of the illustrative Medicaid expansion would increase by that $2.6 billion--$1.5 billion more in federal spending and $1.1 billion more in state spending--an increase of about 9 percent in each case.

Alternatively, the contributions that eligible people would be required to make could be increased, although it might be difficult to collect more in premiums from this low-income population. For example, the contribution rate could be doubled--10 percent of family income above poverty for one person and 20 percent of family income above poverty for two or more people--and the maximum could be raised to the full costs of Medicaid coverage for an average family of each size and type. If every eligible person continued to participate and paid the contribution up to the full cost of the coverage--an unlikely outcome--collections from contributions would rise to $5.5 billion compared with $2.6 billion under the illustrative option--an increase of 112 percent. The total federal and state cost of the Medicaid expansion, would fall by about 10 percent--$25.9 billion compared with $28.8 billion under the illustrative option.

Doubling contribution rates might not increase total contributions at all, however. In a voluntary system, contributions that are high relative to the incomes of those in the eligible population would deter potential beneficiaries from participating in the program. Many low-income families with healthy adults and children would not voluntarily enroll in a program under which their full-cost, family contribution would be $2,500 or more. (The average annual cost per person would be about $1,100.) Thus, charging higher amounts would cut the costs of a Medicaid expansion, but the effect on the number of uninsured people would be commensurately smaller. Moreover, because

healthy people would be the least likely to participate, costs would not fall as much as contributions, meaning that federal and state governments would pay a higher percentage of the cost of this option.

Categories of People Covered by the Expansion

Recent expansions in the Medicaid program have focused on pregnant women, children, and the elderly. Following in this vein, the illustrative Medicaid expansion could be limited to certain categories of those with family incomes below 200 percent of poverty. For example, if the expansion were limited to families with children, it would affect only 17.7 million people at a federal cost of $10.0 billion, a reduction in spending of 39 percent compared with the illustrative option. The effect of this alternative on the uninsured would also be less--15.0 million, or 45 percent, of the uninsured would receive Medicaid coverage compared with 20.2 million, or 61 percent under the illustrative option.

The magnitude of the expansion would, of course, be reduced even further if it were limited to members of single-parent families. Under this alternative, only 7.2 million people would receive new Medicaid coverage, at a federal cost of $4.1 billion, a reduction of about 75 percent compared with the illustrative option. The number of people without insurance would fall by 6.1 million, or 18 percent, under this option compared with 20.2 million, or 61 percent, under the illustrative option.

ADVANTAGES AND DISADVANTAGES OF EXPANDING MEDICAID

The principal advantage of expanding Medicaid is that all additional federal spending would be concentrated on those individuals who are least able to afford private coverage--a maximum income level of 200 percent of the poverty level, for example, would include almost everyone who is usually thought of as "poor" or "near-poor." Furthermore, almost 80 percent of the spending under this option would be to provide insurance to the currently uninsured.

Another advantage is that an expansion in Medicaid would not require the poor, or businesses that employ low-wage workers, to pay for significant additional health care costs. People with incomes under the poverty level, in fact, would pay no premiums and have virtually no out-of-pocket costs under this approach.

A major disadvantage of expanding Medicaid would be its effect on federal and state spending--an increase of about $16 billion and $12 billion in 1991, respectively, under the illustrative option. Taxes would have to be increased or other spending reduced significantly at both the federal and the state level to pay for further expansions. State governments already face federally legislated Medicaid expansions--about $1 billion in 1992 for coverage of pregnant women and children alone. (States face federally mandated expansions for the aged, blind, and disabled as well.) A sudden increase of $12 billion in Medicaid spending would cause a major funding crisis for the states.

Expanding Medicaid also would be administratively complicated, involving means testing of many more people. Under the current system, Medicaid is on a monthly accounting system. If this system were continued and extended to premium collections, then the Medicaid program would not only have to keep track of eligibility for 25 million new beneficiaries, but it would also have to collect small and varying premiums from each family every month.

Another disadvantage of Medicaid as a source of insurance for the currently uninsured is its welfare stigma. Because Medicaid is closely associated with the welfare system, some potential beneficiaries will not participate because of the welfare stigma. Medicaid also has a second-class status as a payer for health care in many states. The reimbursement levels in many states may be so low that some Medicaid beneficiaries have limited access to health care providers. Moreover, if budget problems worsen in the states, the program could be cut back even further.

Finally, a major Medicaid expansion could lead certain firms to terminate their company insurance benefits. More than 25 million people with incomes below 200 percent of poverty now have employment-based health insurance coverage. If the illustrative

Medicaid expansion were enacted, employers with a large proportion of low-wage workers would have an incentive to drop their health insurance benefits, even though doing so would adversely affect their higher-wage employees. Furthermore, many low-income workers might be willing to trade insurance for higher wages, especially if Medicaid coverage were available free or at highly subsidized rates. These responses by employers and their employees could cause state and federal government spending under this option to be even higher than the estimates presented above that were based on an assumption that existing employment-based insurance coverage would not be reduced.[2]

2. For a more comprehensive discussion of Medicaid expansions, see John Holahan and Sheila Zedlewski, "Insuring Low-Income Americans Through Medicaid Expansion," Urban Institute Working Paper No. 3836-02 (December 1989).

CHAPTER IV

ANALYSIS OF OPTIONS THAT EXPAND BOTH EMPLOYMENT-BASED HEALTH INSURANCE AND MEDICAID

Employer mandates would provide insurance coverage for the uninsured who have some attachment to the work force, either directly or through a family member's employment. An employer mandate approach, however, is likely to exempt some types of firms and workers. These exempted workers and the 20 percent of the uninsured without any workers in their families would continue to be uninsured. Similarly, a stand-alone Medicaid expansion that would provide insurance for those with family incomes below the poverty level, or twice the poverty level, would leave people with higher incomes uninsured.

The analysis presented in this chapter is subject to the limitations that were described in Chapter II as well as those that described in Chapter III. The most critical of these limitations are the assumptions that everyone who is eligible for Medicaid coverage accepts it and that no changes in employment would occur.

AN ILLUSTRATIVE COMBINATION PLAN

This illustrative plan would require employers (with 10 or more employees) to provide health insurance to every worker, who worked 25 hours or more per week, and would expand the Medicaid program in order to reduce the number of uninsured people. Specifically:

- All employers with 10 or more employees, including governments, would have to offer a qualified insurance plan to employees who worked 25 hours or more per week and to the employees' dependents.

- All individuals and families whose incomes were below 100 percent of poverty would be eligible for Medicaid coverage (without cost). Individuals and families whose incomes were

below 200 percent of the poverty level (but greater than or equal to 100 percent of the poverty level) could "buy in" to Medicaid based on the sliding scale described in Chapter III.

- Workers and their dependents would receive employment-based coverage under the mandate, but would have Medicaid as a second payer if their family income was under 100 percent of poverty.

Under this combination, Medicaid would complement employment-based coverage. About 38 percent of the uninsured who would not be affected by the illustrative employer mandate would have family incomes below the poverty level, and another 30 percent would have incomes below 200 percent of poverty. Thus, this combination could cover significantly more of the uninsured than either part alone.

ANALYZING THE ILLUSTRATIVE PLAN

The illustrative plan would potentially provide health insurance coverage for up to 85 percent of people who are currently uninsured. It would also affect national health expenditures, workers, firms, the U.S. economy, and federal, state, and local budgets.

Effects on People

This illustrative combination would change the insurance coverage of 44.4 million people (see Table 17).[1] The mandated insurance component would provide employment-based coverage for an additional 30.6 million people--exactly as it would have provided under the stand-alone mandate. The Medicaid expansion would provide additional coverage as the primary payer for 13.8 million people, compared with 25.3 million under the stand-alone Medicaid expansion. This difference arises because 11.5 million poor, or near-poor, uninsured people live in families where someone works enough to gain employment-based in-

1. As was the case in the previous chapter, the estimates of people affected by the options in this chapter are based on the March 1990 Current Population Survey. The estimates are not adjusted to reflect population changes since March 1990.

surance under the mandate. (Of this group, 4.2 million with incomes under the poverty level would continue to be eligible for secondary coverage from Medicaid.)

Of the 28.4 million newly insured people, 17.6 million would receive employment-based coverage and 10.8 million would receive Medicaid. In addition to providing insurance for the previously uninsured people, the plan would provide new employment-based coverage for another 13.1 million people and new Medicaid coverage for 3.0 million people who previously had some other form of insurance.

Although 85 percent of the uninsured would receive coverage, some groups would be helped more than others. Almost all uninsured children would receive coverage--7.9 million, or 93 percent (see Table 18). The Medicaid component of the combination would ensure that all

TABLE 17. INSURANCE STATUS OF PEOPLE BEFORE AND AFTER ENACTMENT OF BOTH AN ILLUSTRATIVE EMPLOYER MANDATE AND AN ILLUSTRATIVE MEDICAID EXPANSION (In millions)

	Before Enactment	Continuing Existing Coverage	Changes in Coverage		Coverage After Enactment
			Employment-Based	Medicaid	
Total	246.2	201.7	30.6	13.8	246.2
Insured	212.8	196.7	13.1	3.0	241.2
Employment-based	152.3	152.3	0.0	0.0	182.9
Public					
Medicare	30.5	28.8	1.7	0.0	28.8
Medicaid	14.6	11.8	2.8	0.0	25.6
Veterans Affairs	0.8	0.2	0.4	0.2	0.2
Other private	14.7	3.7	8.2	2.8	3.7
Uninsured	33.4	5.0	17.6	10.8	5.0

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

NOTE: In general, people covered by more than one source of insurance are classified by the primary source. For example, retired elderly Medicare beneficiaries are classified there, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. In contrast, the working aged, whose plans are primary payers to Medicare, are classified under employment-based coverage.

TABLE 18. CHARACTERISTICS OF THE UNINSURED BEFORE AND AFTER ENACTMENT OF BOTH AN ILLUSTRATIVE EMPLOYER MANDATE AND AN ILLUSTRATIVE MEDICAID EXPANSION

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Illustrative Option
All Uninsured	33.4	5.0	84.9
Age and Sex			
Children	8.5	0.6	93.1
Young Adults, 18 to 24	6.4	1.2	81.4
Women			
25 to 34	3.3	0.4	88.4
35 to 44	2.1	0.3	88.1
45 to 54	1.7	0.3	84.6
55 to 64	1.5	0.4	73.6
Men			
25 to 34	4.6	0.9	79.8
35 to 44	2.5	0.5	81.5
45 to 54	1.5	0.3	80.6
55 to 64	1.0	0.2	79.3
Elderly, 65 and over	0.3	0.1	67.9
Family Income as a Percent of Poverty (1989)			
Below 100	9.6	0.0	100.0
100 to 199	10.6	0.0	100.0
200 to 299	5.9	2.3	61.4
300 or higher	7.2	2.8	61.9
Maximum Hours by Family Worker[a]			
None	8.8	2.2	74.5
1 to 24 hours	2.0	0.7	65.7
25 to 34 hours	2.7	0.2	91.6
35 or more	19.9	1.9	90.6
Race			
White	25.9	4.2	83.9
Black	5.8	0.6	89.5
Other	1.7	0.3	85.1
Family Structure			
Unrelated individual	6.0	0.8	86.4
Single-parent family	9.1	1.4	84.5
Two-parent family	15.7	2.4	84.7
Childless couple	2.6	0.4	83.9

(Continued)

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey.

NOTE: Details may not add to totals because of rounding.

TABLE 18. Continued

Characteristic	Before Enactment (Millions)	After Enactment (Millions)	Percentage of Uninsured Who Would Be Covered by Illustrative Option
Major Activity			
Working	14.9	2.1	85.9
Looking for work	1.2	0.4	65.6
Keeping house	4.0	0.6	84.1
In school	2.9	0.5	84.4
Unable to work	0.4	0.1	72.2
Retired	0.5	0.2	59.7
Other	2.5	0.6	74.3
Child under 18	7.0	0.5	93.0
Family Work Status[b]			
Employed	26.8	3.8	85.9
Unemployed	2.0	0.4	78.7
Not in labor force	4.6	0.8	82.1
Marital Status			
Married, spouse present	9.5	1.2	87.7
Separated	1.7	0.3	82.7
Divorced	3.0	0.6	80.6
Widowed	0.9	0.2	77.7
Never married	9.8	2.2	77.4
Child under 18	8.5	0.6	93.1
Census Division			
New England	1.1	0.3	75.6
Middle Atlantic	4.0	0.8	79.8
South Atlantic	6.2	0.8	86.4
East North Central	3.9	0.6	83.3
East South Central	2.2	0.2	90.7
West North Central	1.7	0.3	84.9
West South Central	5.5	0.5	91.1
Mountain	2.0	0.3	83.8
Pacific	6.7	1.2	82.5

a. Hours worked last week by head or spouse, whichever is greater. Nonstudents who were 19 or older and students who were 24 or older are treated as separate individuals in this calculation. For that reason, the 8.8 million people with no hours of work include 2.2 million people who live in families where the head or spouse work but who were not included in the family.

b. A family's work status is defined as follows:

- Employed, if either the head or spouse is employed.
- Unemployed, if neither the head or spouse is employed and one or both are unemployed.
- Not in labor force, if neither the head nor the spouse is in the labor force.

of the poor and near-poor uninsured could be covered. The employer mandate component would ensure that substantial numbers of uninsured workers and their families received new employment-based coverage. Thus, this dual path to insurance coverage would make certain that few distinct demographic and socioeconomic groups would be poorly covered. Two small groups who would be exceptions: the uninsured who are retired (59.7 percent would receive coverage), and those who are looking for work (65.6 percent would receive coverage).

Effects on Health Spending

Under this combination, total health care spending in the nation could increase by $20 billion--an increase of about 2.7 percent (see Table 19). This relatively modest increase in national spending for health care would be the net result of a $53 billion increase in Medicaid spending and employment-based insurance premiums offset by a $34 billion reduction in other spending by governments and individuals.

This $53 billion in new spending would consist of $35 billion more in employment-based premiums and $18 billion more in Medicaid spending. The $35 billion in new spending under employment-based plans--an increase of 15.8 percent compared with current spending on employment-based coverage--would consist of $34 billion for new coverage and $1 billion to upgrade existing policies to the minimum required under the employer mandate. Spending on other private insurance policies would fall by $6 billion.

Government spending on health care could increase by $9 billion, or 3.0 percent, depending on participation of those with family incomes between 100 percent and 200 percent of the poverty level.[2] The federal government could spend about $7 billion more--the difference between $3.6 billion less under Medicare and $10.2 billion more in Medicaid spending. (The $10.2 billion increase in federal Medicaid spending is, in turn, the net result of an increase in Medicaid spending of $11.3 billion from the Medicaid expansion offset by a reduction in Medicaid

2. In addition, revenues would be affected. See the discussion in the section, "Effects on Federal, State, and Local Budgets."

spending of $1.1 billion from the employer mandate.) State and local governments could spend about $3 billion more. In contrast, patients could pay $18 billion less in out-of-pocket costs--$19 billion in lower copayments offset by about $1 billion in Medicaid contributions.

Effects on Workers, Firms, and the National Economy

Because the employer mandate would be the same under the combination plan as the illustration in Chapter II, its effects on workers, firms,

TABLE 19. NATIONAL HEALTH EXPENDITURES BEFORE AND AFTER ENACTMENT OF BOTH AN ILLUSTRATIVE EMPLOYER MANDATE AND AN ILLUSTRATIVE MEDICAID EXPANSION
(In billions of 1991 dollars)

Source of Payment	Before Enactment	After Enactment	Change
Total	740	760	20
Private Insurance	238	267	29
Employment-based	222	257	35
Employer share[a]	184	210	26
Employee share	38	46	9
Other	17	10	-6
Government	321	331	9
Federal	220	226	7
Medicare	123	120	-4
Medicaid	52	62	10
Other	44	44	b
State and local	102	104	3
Medicaid	40	47	8
Other	62	57	-5
Other	180	162	-18
Direct patient	149	131	-18
Other	31	31	b

SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration.

a. Includes premium payments by federal, state, and local government agencies on behalf of government employees.

b. Less than $500 million.

and the national economy should be roughly the same as those described earlier. Some interactions, however, are possible. For example, if the combination plan led to more inflation in medical care than that under the stand-alone mandate, the effects on workers, firms, and the national economy would be somewhat more severe than those described above. On the other hand, under the combination plan the possibility of employers dropping their group coverage that would exist under a stand-alone Medicaid expansion would be eliminated.

Effects on Federal, State, and Local Budgets

This option would result in an estimated $13.1 billion increase in the federal budgetary deficit (see Table 20). Federal outlays for health care would increase by about $6.6 billion in 1991--the net result of $10.2 billion higher Medicaid spending offset by $3.6 billion lower Medicare spending. In addition, federal revenues from income and

TABLE 20. EFFECTS ON THE FEDERAL BUDGET OF BOTH AN ILLUSTRATIVE EMPLOYER MANDATE AND AN ILLUSTRATIVE MEDICAID EXPANSION
(In billions of 1991 dollars)

Budget Component	Effect
Federal Deficit	13.1
Outlays	6.6
Medicare	-3.6
Medicaid	10.2
Other	a
Revenue Loss	6.5
Individual income tax	3.0
Social Security and Medicare payroll taxes	3.5

SOURCE: Congressional Budget Office estimates based on the March 1990 Current Population Survey and other sources.

NOTE: Negative outlays reduce the federal deficit, and positive revenue losses increase it.

a. Less than $500 million.

payroll taxes would fall by $6.5 billion, again because of the different taxation of wages and fringe benefits.

The illustrative employer option would increase spending by state and local governments while reducing their tax revenues. State and local outlays would rise by about $3 billion--$8 billion in new outlays for Medicaid, offset by $5 billion in reduced spending for indigent care. State and local income tax revenues would fall by about $1 billion because compensation paid to workers would shift from taxable wages and salaries to health insurance premiums not subject to tax. In the longer run, state and local sales and excise tax revenues would also tend to decline as spending shifted to untaxed medical goods and services from other consumption subject to taxes. Because many state and local governments operate under balanced budget requirements, new revenues would have to be raised or other spending reduced to offset the lost tax revenues and increased spending.

ALTERNATIVE SPECIFICATIONS

The illustrative option could be scaled down or expanded in scope and the mix between public- and private-sector expansions could be altered as well (see Box 1). The alternative specifications shown in Box 1 illustrate only a few of the many possibilities.

Two of the alternative combinations (Option A and Option B) would provide less new coverage for the uninsured than the basic illustrative one (Option C). Option A would do this by limiting the employer mandate to firms with 25 or more employees (compared with firms of 10 or more employees under the basic option). Option B would do this by limiting the Medicaid expansion to include only those with family incomes below the poverty level.

Medicaid would automatically expand to provide coverage for some of the uninsured workers and their families who would be left out under Option A. For that reason, the number of previously uninsured covered by Option A would be reduced by only 8 percent compared with the basic combination--even though the number of people covered by new employment-based insurance policies would be 34 percent fewer

under Option A (see the table in Box 1 on page 65). Option B, however--in which the Medicaid component would be scaled back--would provide coverage for 23.6 million of the currently uninsured (a reduction of 17 percent compared with the basic combination) because no automatic expansion in employment-based coverage would fill in the gap opened by the reduction in Medicaid coverage.

BOX 1
Alternative Combinations of Employer Mandates and Medicaid Expansions

The following alternative combinations of an employer mandate and a Medicaid expansion represent a few of the many possible ways that the two policies might be combined.

Option A: Limited Employer Expansion Combined with the Illustrative Medicaid Expansion. Under this option, the employer mandate would be limited to firms with more than 25 employees and combined with the illustrative Medicaid option of Chapter III.

Option B: Illustrative Employer Mandate Combined with Limited Medicaid Expansion. Under this option, the illustrative employer mandate of Chapter II would be combined with Medicaid coverage limited to families at or below the poverty level.

Option C: Illustrative Employer Mandate Combined with the Illustrative Medicaid Expansion. Under this option, the illustrative employer mandate of Chapter II would be combined with the illustrative Medicaid option of Chapter III.

Option D: Illustrative Employer Mandate Combined with High Medicaid Expansion. Under this option, the employer mandate of Chapter II would be combined with Medicaid coverage for everyone with family income under 300 percent of poverty.

Option E: Employer Mandate for Firms Regardless of Size with the Illustrative Medicaid Expansion. Under this option, the employer mandate would be expanded to include all firms regardless of size and combined with the illustrative Medicaid expansion of Chapter III.

Option A, with a more limited employer mandate, would increase employment-based coverage by 20.2 million people and employment-based insurance costs by $23.6 billion compared with 30.6 million people and $35.1 billion under Option B. Option A, however, would have higher Medicaid costs compared with Option B--$21.8 billion compared with $11.1. For this reason, Option B would increase the fed-

EFFECTS OF ALTERNATIVE COMBINATIONS OF EMPLOYER MANDATES AND MEDICAID EXPANSIONS

	Option A	Option B	Option C	Option D	Option E
	People (Millions)				
People Affected by the Mandate	20.2	30.6	30.6	30.6	39.2
People Affected by Medicaid	18.0	7.3	13.8	17.4	10.2
Uninsured Covered with New Insurance	26.0	23.6	28.4	30.6	30.4
Remaining Uninsured	7.4	9.8	5.0	2.8	2.9
	Spending (Billions of 1991 dollars)				
Increase in National Health Expenditures	18.1	16.5	20.1	22.0	21.7
Increase in Employment-based Insurance Costs	23.6	35.1	35.1	35.1	44.8
Increase in Federal and State Medicaid Costs	21.8	11.1	17.9	21.0	14.5
Increase in Federal Deficit	14.5	9.3	13.1	14.9	11.8

SOURCE: Congressional Budget Office tabulations based on national health expenditures data from the Health Care Financing Administration (Office of the Actuary), the March 1990 Current Population Survey, and other sources.

eral deficit by only $9.3 billion compared with $14.5 billion under Option A.

Two of the alternative combinations (Option D and Option E) would provide more new coverage than the basic one. Option D would do this by expanding Medicaid eligibility to everyone whose family income is below 300 percent of the poverty level. Option E would do this by including all firms regardless of size in the mandate. Either of these options would expand new coverage for the uninsured by about 7 percent more than the basic combination.

These two alternatives would, however, achieve this increase in coverage quite differently. Option D would expand Medicaid coverage to 17.4 million people, or about a quarter more than the illustrative combination, while employment-based insurance would increase by 30.6 million people, the same as under the basic combination. Alternatively, Option E would increase employment-based coverage for substantially more people--39.2 million or 28 percent more than either the illustrative option or Option D, with a commensurately smaller expansion in Medicaid eligibility.

Under Option D, Medicaid costs would rise by $21.0 billion, about 45 percent higher compared with new Medicaid costs under Option E. Option E, however, would increase employment-based costs by $44.8 billion, about 28 percent higher than under either the basic combination or Option D. The federal deficit would increase by $14.9 billion under Option D compared with $11.8 billion under the Option E. Because employers would provide coverage for workers in firms with fewer than 10 employees, Medicaid would be only a secondary payer for those workers and dependents whose family income was below 100 percent of poverty.

ADVANTAGES AND DISADVANTAGES OF THE COMBINED APPROACH

Under the basic combination employer mandate and Medicaid expansion, nearly all the uninsured would be newly covered by insurance.

Only 5 million people, or about 2 percent of the population, would remain without health insurance.

The employer mandate component of the basic option, which is identical to the main illustration of Chapter II, would have the same advantages--coverage for a large proportion of the uninsured, minimum interference with existing insurance arrangements, and only a small increase in the federal deficit. The Medicaid expansion under the illustrative combination, however, would be much smaller than the stand-alone version (with total federal and state costs of $17.9 billion compared with $28.8 billion). Moreover, with an employer mandate in place, there would be less potential for changes in employer behavior in offering insurance than under a stand-alone Medicaid expansion.[3] Thus, currently insured low-income workers face less risk of losing their coverage. Finally, this combination would generate a smaller increase in the federal deficit than a stand-alone expansion of Medicaid ($13.1 billion compared with $16.4 billion).

The employer mandate component would also have the same disadvantages as the stand-alone mandate--potential reductions in employment for low-wage workers, adverse effects on small firms, and limits on choices for workers and firms. Moreover, under the Medicaid component of the combination, workers with family incomes below the poverty level would face much higher premiums for their private insurance than they would as Medicaid participants under the stand-alone Medicaid expansion. This outcome would be mitigated somewhat if state Medicaid programs were required to pay premiums for workers with family incomes under the poverty level. By doing so, however, it would increase federal spending by $1.1 billion and state spending by $800 million. (Under current law, states have the option of paying the premiums but only three states have chosen to do so.)

While all of the combinations examined here would dramatically lower the number of uninsured, the preferred way of combining an em-

---

3. Under a mandate, employers would not be allowed to drop coverage for workers whose hours are above the threshold. Employers, however, would continue to have an incentive to reduce hours below the threshold and avoid the mandate. Under a stand-alone mandate, workers would lose health insurance and hours of work if their employers reduced their hours. Under the combination approach, low-income workers would lose hours of work, but would obtain coverage through Medicaid.

ployer mandate with a Medicaid expansion would depend on the relative importance of other objectives. If the most important objective is to minimize the increase in the federal deficit, while still providing additional insurance coverage, then Option B--which would combine an employer mandate with expansion of Medicaid only to those families at or below the poverty level--would be preferred. Even here, though, the deficit would rise by $9.3 billion.

If the greatest priority is given to reducing the number of people without insurance, then Option D--would which combine an employer mandate with a Medicaid expansion that would cover families with incomes up to 300 percent of poverty--would be preferred. But it would be costly--the federal deficit would rise by $14.9 billion, states would spend $3.7 billion more, and employers (through lower profits) or employees (through lower wages or higher prices) would pay $26.3 billion.

Then, again, if minimizing the impact on employer spending was the goal, Option A--which would combine the Medicaid expansion with an employer mandate limited to firms with 25 or more employees--would be preferred. Under this alternative combination, the federal deficit would increase by $14.5 billion and the number of uninsured would fall by 78 percent, while employment-based spending would rise by 11 percent (compared with 16 percent under the basic combination).

Finally, if maximizing the number of people with employment-based insurance--that is, emphasizing the private sector--is the highest priority, then Option E--which would combine the Medicaid expansion with an employer mandate for all firms regardless of size--would be preferred. About 22 percent of the newly insured under this alternative would be employees of firms with fewer than 10 employees--firms that would be financially weaker, on average, compared with larger firms.

APPENDIX A

ESTIMATING PROCEDURES

The descriptions of analyses presented above omitted the technical aspects of how the estimates were derived. This appendix provides more detail on the sources of data and the estimation techniques. For expositional convenience, this description is restricted to the illustrative employer mandate and the illustrative Medicaid option. The same general methods were used to analyze the illustrative combination option, as well as the alternative specifications of each approach.

THE CURRENT POPULATION SURVEY

The estimates presented in this study were based on the March 1990 Current Population Survey, augmented by data from other sources. The CPS collects labor force and other data about the civilian, noninstitutional population each month. Interviewers ask questions concerning labor force participation about each member in every sample household who is 14 years or older. In March of each year, the interviewers ask supplementary questions, including a series about sources of health insurance.

The CPS has a number of advantages for analyzing health insurance options. An important one is the large number of respondents: 57,400 households containing more than 150,000 people were interviewed in March 1990. Another advantage of the CPS for analyzing employer mandates is the large number of employment-related questions that the respondents are asked. The CPS also contains information about cash income received the previous calendar year--a key element for estimating Medicaid eligibility and tax liability. Yet, another major advantage of the CPS is its timeliness. The health insurance questions are asked annually in March and the results are generally available in September.

The CPS does have some disadvantages, however. The most serious problem concerns timing of the health insurance questions. Although the questions ask about health insurance coverage in the previous year, the answers suggest that respondents frequently respond as if they were being questioned about coverage on the day of the interview. For example, the March 1990 CPS asks, "During 1989 was anyone in this household covered by Medicaid?" The pattern of responses strongly suggests that a majority of respondents answer the above question as if it were worded, "Is anyone in this household now covered by Medicaid?"

In other words, it appears that estimates of the number of people without insurance based on the CPS actually reflect insurance status at the time of the interview rather than insurance status throughout the preceding calendar year. In fact, the number of people who did not appear to have any health insurance coverage after answering a series of such questions in March 1990 was 33.4 million--a figure that corresponds closely to that from other surveys, such as the Health Interview Survey and the Survey of Income and Program Participation, in which the questions ask about current health insurance coverage. Although the estimates in this study were based on the assumption that health insurance status was reported for March 1990, some people probably reported their status for 1989, and, in some cases, they were not the same.

Another time-related problem with the CPS is the lack of data on intrayear variation in income, job status, and health insurance coverage. Medicaid, for example, is based on a monthly accounting system--a person is eligible or not in a given month depending on income and assets in that month. Estimates of Medicaid eligibility in this study, however, had to be based on annual income rather than the correct value of monthly income.

The CPS also has all of the shortcomings of the U.S. Census of Population. More specifically, certain groups of people--the poor, for example--are systematically undercounted and certain characteristics--interest income, for example--are systematically underreported. In addition, certain people like the homeless and the institutionalized are not included in the household sample frame. All of these errors and

omissions either understate or overstate the number of people who would be eligible for an expanded Medicaid program.

CLASSIFYING PEOPLE BY TYPES OF HEALTH INSURANCE

Classification of people into insurance categories is complicated by some people having coverage from more than one source. If a person can be in more than one insurance category, then the percentages by type of insurance may sum to more than 100 percent. This untidy feature of insurance classification can be avoided by assigning each person to one category of insurance. In order to do this, a hierarchy must be defined so that a person with two or more types of coverage is placed in only one category.

The results in this study were based on the concept of primary payer, which in turn was based on the following hierarchy: employment-based, Medicare, Medicaid, Department of Veterans Affairs (VA), and individually purchased coverage. Employment-based coverage had first place in this hierarchy. If a person was covered by an employment-based plan, he or she was categorized as having employment-based coverage regardless of any other coverage. For example, if someone had both Medicaid and employment-based coverage, then that person was categorized as having employment-based coverage. As another example, if someone had both Medicare and Medicaid, then that person was classified as having Medicare coverage.

This hierarchy was based partly on law, partly on practice, and partly on convenience. Employment-based coverage is primary to Medicare and Medicaid by law. Medicare is primary to Medicaid by law as well. People receive treatment through the Department of Veterans Affairs based on their service connection and on the availability of other coverage. If a person with both Medicaid and VA coverage went to a non-VA facility for care, Medicaid would be recognized as the primary payer. The ranking of employment-based, Medicare, Medicaid, and VA is supported by law and practice.

The treatment of individually purchased insurance was a matter of convenience. If someone had both Medicaid and an individually purchased policy, the private insurance would be primary payer for any medical treatments that it covered. For that reason, this type of coverage might come before Medicaid in the hierarchy. Alternatively, the analysis was based on the assumption that a person receiving new coverage, for example, from the Medicaid program, would drop private coverage. This situation suggests that individually purchased health insurance coverage should rank lower in the hierarchy. Another reason for a lower ranking was the suspicion that other private insurance may provide limited coverage in many cases.

ESTIMATING WHO WOULD BE AFFECTED BY OPTIONS

The technique used in estimating the number of people who would be affected by an option depended on whether the option was an employer mandate or a Medicaid expansion.

Employer Mandate

Estimates of who would be affected by the employer mandate began with a definition of a "health insurance unit"--the group of people who could be covered by a worker's employment-based insurance policy. The estimates in this study were based on the CPS-defined subfamily with two exceptions: nonstudents who were 19 or older and students who were 24 or older. These individuals were assumed to be ineligible for coverage under the head's or spouse's health insurance.

With these two adjustments, the subfamily is probably comparable to the health insurance coverage definition used by most insurance companies. Certain exceptions, however, should be noted. For example, a teenage daughter and her child would not be included in the same subfamily as the teenager's father and mother in the analysis--although insurance companies would probably allow the daughter and grandchild to be covered by the father's policy.

Once health insurance units were defined, the eligibility of the entire unit for coverage under the illustrative mandate was determined (see Chapter II). First, the work status of the head and spouse was examined to determine whether either worked 25 hours or more per week in a firm with 10 or more employees. If one or both of them met this work requirement, then every member of the subfamily (with the aforementioned exceptions) was assumed to be eligible for an employer mandate.

Members of families who were assumed to be eligible for the illustrative mandate were not counted in the estimate of people the mandate affected unless they did not have employment-based insurance before the mandate. A subfamily could fall into one of three categories: whole-family mandate in which no one in the family was previously covered by employment-based insurance; partial-family mandate in which at least one person was previously covered by employment-based insurance; and no effect in which everyone in the family was previously covered by employment-based insurance.

Medicaid Expansion

Estimates of who a Medicaid expansion would affect were based on the CPS family unit definition and on family income data from the CPS. People would become newly eligible for Medicaid coverage if their family income was below 100 percent of poverty and if they did not already have Medicaid coverage. People who had employment-based or Medicare coverage would be eligible for Medicaid as a secondary payer, while people who had individually purchased private policies or VA coverage would be eligible for Medicaid as a primary payer.

People would be eligible to buy Medicaid coverage if their family income was below 200 percent of poverty, if they did not already have Medicaid coverage. People who had individually purchased private policies or VA coverage would be eligible to purchase Medicaid as a primary payer.[1] As discussed in Chapter III, the estimates of people

1. These estimates are based on the assumption that Medicaid secondary coverage was not available for people whose family incomes were above 100 percent of poverty. Even if it were offered, however, most of these people probably would not choose to pay for secondary coverage.

covered by Medicaid were based on the assumption that everyone who would be eligible for new Medicaid coverage would be willing to accept the coverage and pay whatever contribution was required.

ESTIMATING THE COSTS OF HEALTH BENEFITS

Costs of insurance coverage were estimated differently for the employer mandate and the Medicaid expansion. Costs for the combined approach, of course, were based on a combination of the two methods.

Employer Mandate

It is necessary to know insurance premium costs in order to estimate how much the employer mandate would cost employers and workers. Actuarial Research Corporation (ARC) provided the premiums used in

TABLE A-1. CHARACTERISTICS OF TYPICAL INSURANCE PLANS COVERING EMPLOYEES AT SELECTED LEVELS OF EMPLOYER GENEROSITY (In 1991 dollars)

	Percentage of Employees Covered by Less Generous Plan and Plans at Generosity Percentiles of:				
	10	25	50	75	90
Whole Group Premium					
Single	1,341	1,443	1,577	1,592	1,729
Family	2,902	3,111	3,431	3,546	3,813
Deductible					
Single	250	125	125	120	60
Family	475	375	250	240	180
Coinsurance (Percent)					
Hospital	20	20	20	0	0
Physician	20	20	20	20	0
Other	20	20	20	20	20
Catastrophic Limit	875	575	450	a	a

SOURCE: Prepared by Actuarial Research Corporation, Annandale, Virginia.

a. This plan would have no coinsurance or deductibles on inpatient hospital care. Out-of-pocket costs would be limited to ambulatory care.

this study. ARC estimated premiums for whole family coverage in 1991 at $2,902; for partial family coverage at $1,561; and for individual coverage at $1,341 (see Table A-1).

The estimated premium for new employment-based coverage was assigned to one worker in each family. In the event that only one member of the family worked 25 hours or more per week in a firm with 10 or more employees, then that member was assigned the premium. If both the head and spouse worked, then the premium was randomly assigned to one of them. Employers were assumed to pay 75 percent of the premium for each worker.

The data from ARC were also used to estimate the costs to improve benefits for workers who are currently covered by employment-based policies that would not meet the minimum benefits under the mandate--the so-called "upgrade costs" of a mandate. The five data points in Table A-1 were used to estimate the costs of an upgrade (see Table 12 in Chapter II). This estimation was accomplished by assuming that the distribution of the least generous plan resembled the tail of a normal distribution that passed through the 10 percentile level at $2,902--the point estimated by ARC.

Medicaid Expansion

The total federal cost per person for each year of Medicaid primary coverage was based on the following schedule of federal Medicaid costs by age and sex:

Age	Costs (1991 dollars) Males	Females
Under 18	375	375
18 to 24	409	614
25 to 29	450	655
30 to 34	450	737
35 to 39	532	790
40 to 44	655	790
45 to 54	819	860
55 to 59	1,064	1,187
60 to 64	1,310	1,432
Over 64	2,359	2,359

Total Medicaid costs for each age and sex category were calculated by adding state spending to the federal costs. State spending is about 75 percent of federal spending. For example, total Medicaid costs for a child under 18 were estimated to be $658--the sum of $375 in federal costs and $283 in state costs.

For those with income greater than poverty but lower than twice that level, the estimated maximum contribution to these costs required from each family was based on the number of people who would receive primary coverage in the family: one child, one adult, family with two members, and family with three members. For each of the four family categories, the average actuarial value was calculated (based on the schedule of Medicaid costs listed above) and the maximum required contribution per family or person was set equal to one-third of that value. Specifically, the rates were:

Type of Family Unit	Contribution (1991 dollars)
Child	220
Adult	445
Two-Person Family	815
Three-Person Family	1,260

Each of these rates is about one-third of the average Medicaid costs for that type of unit. For example, $220 is about one-third of the $658 annual Medicaid cost for a child.

The total costs for a Medicaid expansion were calculated as the sum of the costs for Medicaid primary coverage and the costs for Medicaid secondary coverage, less contributions by families above 100 percent of poverty. Secondary coverage was assumed to be equal to 25 percent of the cost for primary coverage. For example, the federal cost of primary coverage for an eligible child would be $375, while the federal cost for secondary coverage would be about $94.

ESTIMATING THE EFFECTS ON NATIONAL HEALTH EXPENDITURES

Estimating how the various options would affect national health spending required information from outside the Current Population Survey, as well as a number of assumptions.

National Health Expenditures for 1991

The estimates of 1991 national health expenditure and its components were based on the 1989 national health expenditure estimates from the Health Care Financing Administration, Office of National Health Statistics. Two separate components of total national health expenditures were estimated:

- Medicare and Medicaid spending in 1991 were from the 1991 CBO baseline estimates, which assume an annual growth rate of 9.9 percent for Medicare and 21.2 percent for Medicaid from 1989 to 1991.

- All other components of national health expenditures were estimated by assuming an annual growth rate of 9.3 percent between 1989 and 1991.

Based on these assumptions, total health expenditures would grow from $604 billion in 1989 to $740 billion in 1991, an annual overall growth rate of 10.8 percent--which is about the growth rate during the 1987-1989 period.

Employer Mandate

The estimate of the impact of the illustrative employer mandate on national health expenditures required, first, an estimate of additional spending on employer-based insurance. This analysis indicated that an employer mandate would result in an additional $35.1 billion in spending for employer-based premiums in 1991. This increase in premiums was multiplied by 0.75--the required employer share under

the mandate--to obtain the change in employer contributions ($26.3 billion) and the change in employee contributions ($8.8 billion).

The reduction in spending for individually purchased insurance premiums partially offsets these costs. Employment-based insurance would cost about $9.1 billion for the 8.2 million people who had individual policies before the mandate. Under the assumption that premiums for privately purchased insurance policies are, on average, about half of the premium for the typical employment-based policy under the mandate, the reduction in spending for private insurance replaced by new employment-based coverage was estimated to be about $4.6 billion.

The estimates of the reductions in Medicaid and Medicare spending that would result from the mandate were based on the numbers of these beneficiaries who would receive new coverage under the mandate and on the CBO estimates of 1991 spending for them. The estimated impact on Medicare spending also took into account lower SMI premium payments to Medicare under the assumption that all the beneficiaries who obtained new employment-based coverage would elect to drop SMI coverage. The estimated impact on Medicaid spending took into account Medicaid benefits not covered by private insurance and copayments under private insurance. These costs would continue to be covered by Medicaid as a second payer.

The estimate of savings in other state spending--specifically, uncompensated care--is the most inexact of the spending estimates. This estimate is based on two assumptions:

- The uninsured currently would use about half the services (in dollar value) of the insured. Moreover, people with privately purchased policies would use about three-quarters of the services of the insured. (Although some of those with individually purchased insurance would have benefits that are equivalent to the typical employment-based plan, others would be underinsured to some extent. At least some of them would hold almost worthless "dread disease" policies.)

- State and local governments, through their support of public hospitals, clinics, and public health departments (or through general medical assistance), were assumed to provide about 25 percent of the value of services that the uninsured would use and about 13 percent of the services that the underinsured would use.

Medicaid Expansion

Changes in national health spending under the Medicaid expansion were derived using the same methods described in the previous section. The change in national health expenditures under the Medicaid expansion would be driven by the $31.4 billion increase in Medicaid spending (not allowing for contributions) that was estimated to result from the expansion. This increased Medicaid spending would lead to a $3.0 billion reduction in state and local spending for charity care and a $3.1 billion reduction in individually purchased private insurance coverage for the same reasons discussed above. Direct patient spending would be reduced by $10.4 billion (even after adjusting for the contribution to Medicaid).